

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Eloise Miller Andrews</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>7</i> Year <i>1968</i>			2b. HOUR <i>11:53P</i>				
3. SEX <i>F</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>5/20/1893</i>		6. AGE in years (last birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOX</i>				
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>Dor</i>		13c. CITY OR TOWN <i>Hurlock</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>John</i> Middle <i>F</i> Last <i>Miller Sr.</i>			15. MOTHER'S MAIDEN NAME First <i>Don't Know</i> Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. James E. Andrews</i>			Address: <i>Hurlock, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vasculitis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Tuberculous meningitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Proteinuria amide</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>2 months</i> <i>18 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>A.S.H.D.</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <i>24 June, 1968</i> , to <i>July 7, 1968</i> , that (I) (we) lost the deceased alive on <i>July 7, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>S P Carney</i>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-8-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>				22e. ADDRESS <i>Easton, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7/11/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington</i>		23d. LOCATION (City or Town) (County) (State) <i>Hurlock Dor Md</i>				
24. FUNERAL DIRECTOR <i>Wm. H. Hurlbrough, East New Market</i>				25. REC'D BY REGISTRAR <i>JUL 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Gertrude Phelps Arter</i>						2a. DATE OF DEATH <i>7 Month 1 Day 1968</i>			2b. HOUR <i>M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5/22/1870</i>		6. AGE (in years lost day) <i>98</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>					
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>211 E. Dover St.</i>			12a. USUAL OCCUPATION (Kind of work done during life even if retired.) <i>Housework</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>211 E. Dover St.</i>		
14. FATHER'S NAME First Middle Last <i>Ira W. Phelps</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Harriett Palmer</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>219-44-1307</i>		17. INFORMANT <i>Theodore J. Arter, Baton Rouge, La.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exposure cerebral arteriosclerosis</i> <i>437.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>My years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>334X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>64</i> to <i>July 1</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>1 July 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>7-3-68</i>							
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M.D.</i>				22e. ADDRESS <i>P.O. Box 929, Easton, Md. 21601</i>							
23a. BURIAL, CREMATION, REMAINS <i>Buried</i>		23b. DATE <i>7/5/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ashtabula</i>		23d. LOCATION (City or Town) (County) (State) <i>Ashtabula, Ohio</i>					
24. FUNERAL DIRECTOR <i>MAURICE E. NEWMAN & SON, Easton, Md.</i>						25a. REC'D BY REGISTRAR <i>JUL - 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10615 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10623		
Item #2a Film GL03 8/1/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) <i>Jeffrey Scott Benson</i>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>July</i> Day <i>24</i> Year <i>1968</i>			2b. HOUR <i>M</i>			
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>12/12/1951</i>		6. AGE (In years last birthday) <i>9</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>Easton R.F.D.</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i></i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Col.</i>				13b. COUNTY <i>UNK.</i>		13c. CITY OR TOWN <i>Denver</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1737 Clermont St.</i>		
14. FATHER'S NAME First <i>Jeffrey</i> Middle <i>Scott</i> Last <i>Bowson, Jr.</i>						15. MOTHER'S MAIDEN NAME First <i>Phyllis</i> Middle <i>Marie</i> Last <i>Coburn</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) <i></i>				16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT ADDRESS <i>Phyllis M. Newman 1737 Clermont St. Denver, Col.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>814.7 HEAD INJURY</i>												
DUE TO, OR AS A CONSEQUENCE OF												
(b) <i>AUTO ACCIDENT</i>												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <i></i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<i>8124</i>												
19a. DATE OF OPERATION <i>7-24-68</i>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <i>1:10P 7-24-68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>RAN ACROSS ROAD INTO PATH OF CAR</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Rt 331 DOVER BRIDGE NR EASTON TALBOT MD</i>				21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i> State <i></i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Sam Shetty</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>7-24-68</i>				
EXAMINER'S NAME (Type) <i>WELTY</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				FOR DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county) <i></i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>			23b. DATE <i>7/27/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fairview</i>			23d. LOCATION (City or Town) (County) (State) <i>Corodan Talbot, Md.</i>				
24. FUNERAL DIRECTOR <i>Ray D. Heverin</i>						ADDRESS <i>Easton, Md.</i>			25a. REC'D BY REGISTRAR <i></i>			
						DATE <i>JUL 29 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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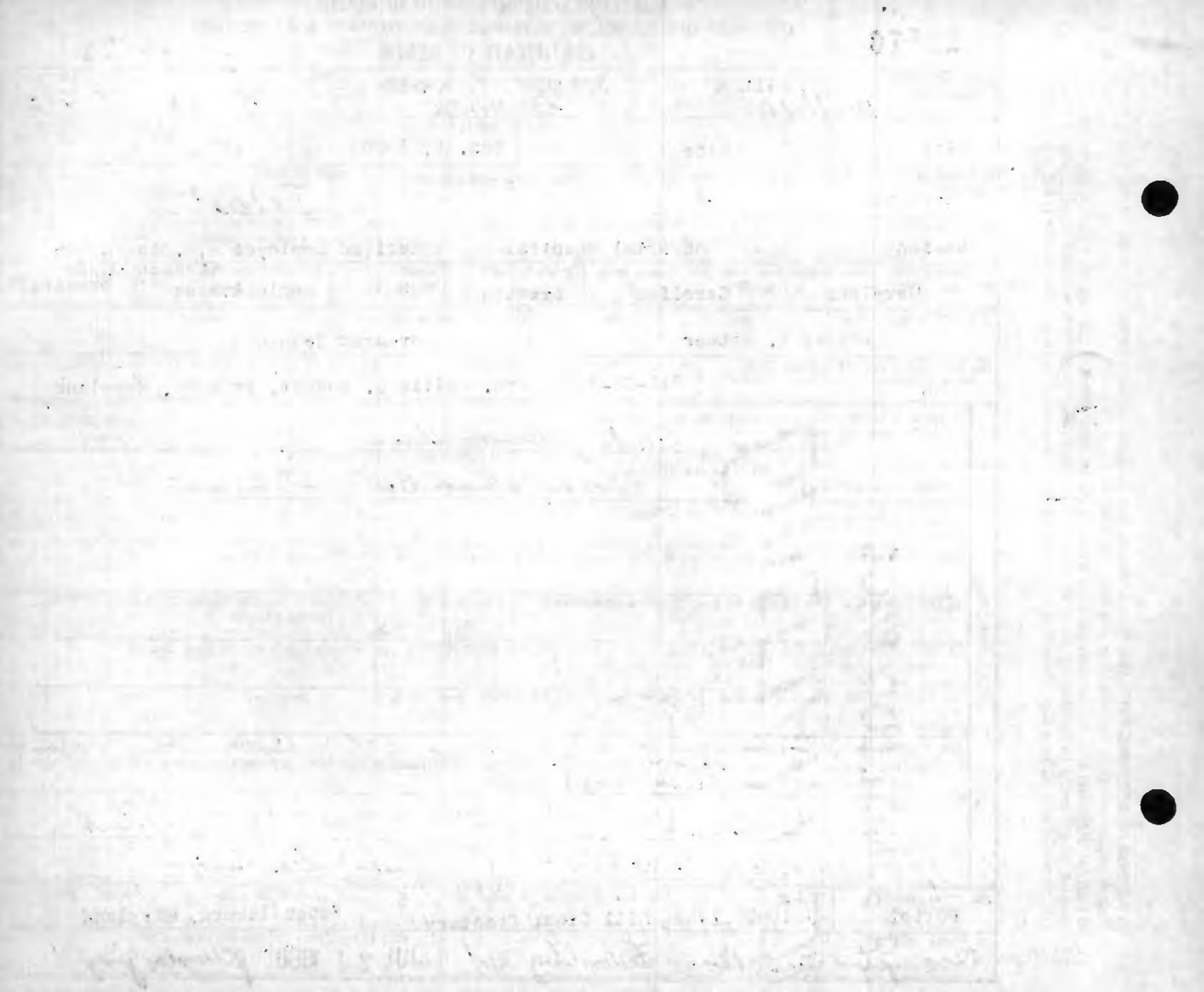
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First WILLIAM		Middle JOHN		Last SON		2a. DATE OF DEATH Month Day Year		2b. HOUR
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 8, 1900		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot		Md.		
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Employee A. W. Sisk & Son		12b. KIND OF BUSINESS OR INDUSTRY Canned Goods Brokers)				
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Maple Avenue		
14. FATHER'S NAME First Middle Last Walter E. Bonner		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Johnson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 212-03-5428		17. INFORMANT Address Mrs. Nellie G. Bonner, Preston, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerotic h.t. disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>38</u> , to <u>18 July</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>18 July</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Thurston Harrison</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>19 July 68</u>				
22d. PHYSICIAN'S NAME (Type) THURSTON HARRISON		22e. ADDRESS <u>Carlton Maryland</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland				
24. FUNERAL DIRECTOR <u>Trampten Funeral Home</u>		ADDRESS <u>Federalsburg Md</u>		25a. REC'D BY REGISTRAR DATE JUL 24 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
FRANKLIN Eugene		BRICE						Month	Day	Year
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD
M	N	8/10/1939		28 YRS		MONTHS DAYS		HOURS MIN		Month Day Year
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				2d. HOUR
Maryland		USA				Talbot				50 PM
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton		Memorial Hospital				Laborer		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Talbot		Easton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #3, Box 182		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Milton		Brice		Mazie		Price				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT						
Yes		Disc. 30 Apr. 1964		215 36 1601		Cora Brummell		Easton Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>G.S.W. Neck</u>										
955X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
976X										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		C Noon 7-2 1968		Shot self in neck						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		None		RD EASTON		Tal		Tal		Ind
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Louis M. Welch		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		WELCH		JW		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-2-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		7/5/68		Chapel		Chapel		Talbot		Maryland
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Barbara L. Dashiell 426 Dover Street Easton, Maryland				JUL - 8 1968		J Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last CORA LEE BROWN			2a. DATE OF DEATH Month Day Year JULY 23 1968		2b. HOUR 6:24 PM	
3 SEX FEMALE		4 RACE Negro		5. DATE OF BIRTH 17 AUG 1918		6 AGE (In years lost birthday) 49 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TALBOT			
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic		12b KIND OF BUSINESS OR INDUSTRY None			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b COUNTY TALBOT		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Port Street			
14. FATHER'S NAME First Middle Last Shannon Bates			15. MOTHER'S MAIDEN NAME First Middle Last Clara Kelley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 213 22 5501		17 INFORMANT Address James Brown 116 Port St., Easton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) NATURAL DEATH 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) HASCVD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) OBESITY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (this hospital) attended the deceased from JULY 1968 , to 23 JULY 1968 , that (we) last saw the deceased alive on 1 JULY 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard Tyson		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-23-68					
22d. PHYSICIAN'S NAME (Type) RICHARD TYSON		22e ADDRESS 2219 LENWOOD AV. EASTON 21601 MARYLAND							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/28/68		23c. NAME OF CEMETERY OR CREMATORY Union Methodist		23d LOCATION (City or Town) (County) (State) Barnwell Barnwell, S.C.			
24 FUNERAL DIRECTOR Barbara L. Lashell		ADDRESS 426 DOVER ST. EASTON, MARYLAND		25a. REC'D BY REGISTRAR JUL 25 1968		25b REGISTRAR'S SIGNATURE Charles Yung			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

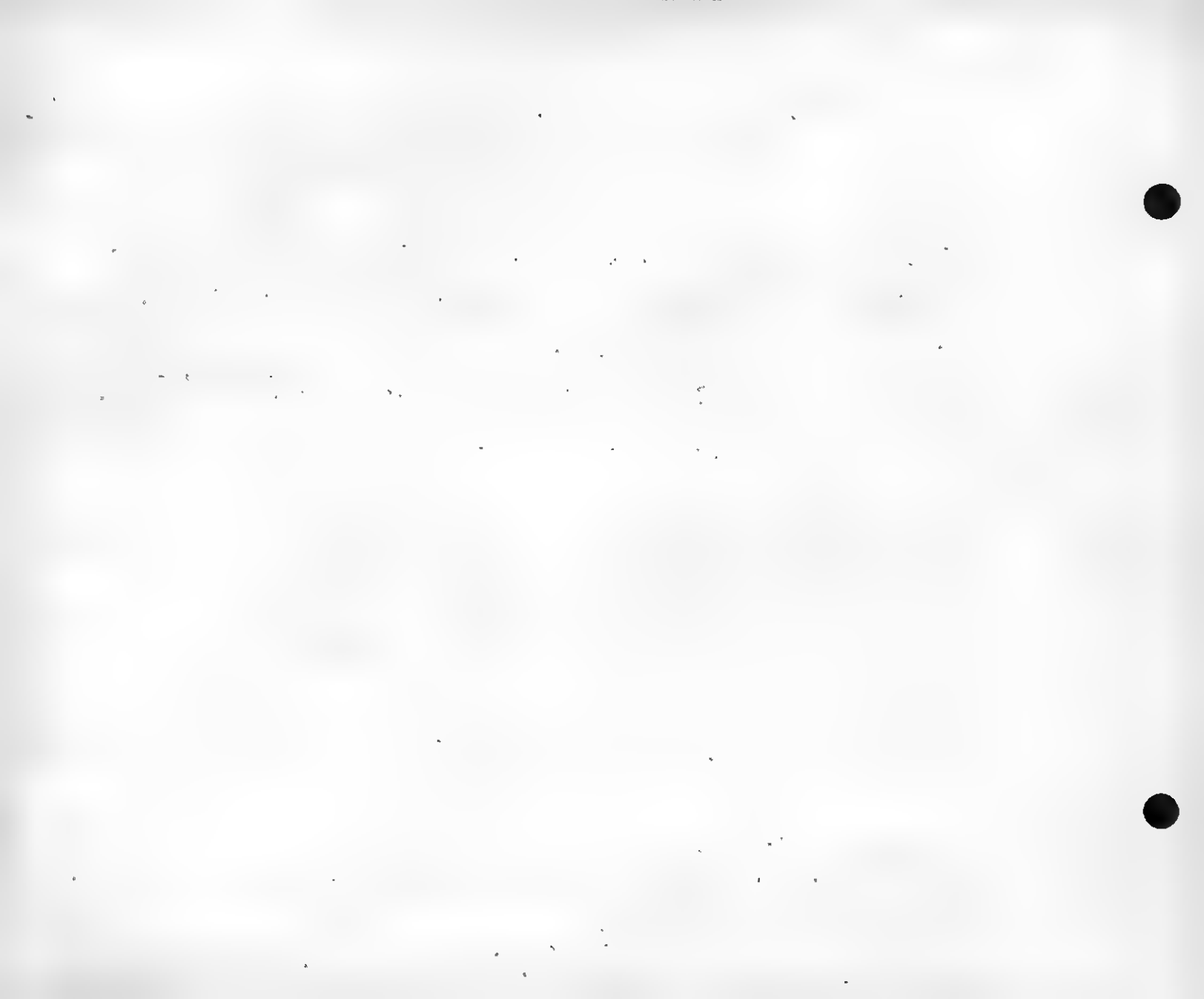
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(M)

19619
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1627

1. DECEASED-NAME (Type or print) Ben First Middle Last			2a. DATE OF DEATH Month Day Year July 6 1968			2b. HOUR 4:05 AM	
3 SEX male		4 RACE Negro		5. DATE OF BIRTH 8-19-00		6. AGE (in years lost birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farming		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Virginia		13b. COUNTY Norfolk		13c. CITY OR TOWN Portsmouth		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 28 Temple St.		14. FATHER'S NAME Ben First Middle Last		15. MOTHER'S MAIDEN NAME Georgianna Faulks First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 719 01 1423		17. INFORMANT Portsmouth, Virginia		17. ADDRESS Bernice Diggs 305 Woodstock St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Basilar artery stroke 4567 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8 July, 1968 , to 6 July, 1968 , that (I) (we) last saw the deceased alive on 6 July, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. P. Carney		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-6-68			
22d. PHYSICIAN'S NAME (Type) A. P. Carney		22e. ADDRESS Memorial Hospital, Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-13-68		23c. NAME OF CEMETERY OR CREMATORY Lincoln		23d. LOCATION (City or Town) (County) (State) Portsmouth Norfolk Va.	
24. FUNERAL DIRECTOR 35 Dashiell		426 Dover St. Easton, Md. 21601		25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 11m 402
7-25-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Type or Print) First Middle Last RONALD JOEL DADDS			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day Year 7-14-1968			2b. HOUR M 3:30	
3. SEX M		4. RACE W		5. DATE OF BIRTH 12-16-41		6. AGE (In years last birthday) 26 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH EASTON				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work week, even if retired) CARPENTER	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) MARYLAND				13b. COUNTY QUEEN ANNE GRASONVILLE		13c. CITY OR TOWN GRASONVILLE	
14. FATHER'S NAME WALTON THOMPSON				15. MOTHER'S M A D E N NAME EVA E. DADDS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO 212-40-9557		17. INFORMANT MRS. BENNY JONES-GRASONVILLE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injury DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auto accident DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 812.4							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 1:50 PM 7-14 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Walked into path of car			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt 50 & Jackson Rd.		21f. LOCATION Street or R.F.D. No Grasonville		21g. City or Town Q.A.	
21h. County Q.A.		21i. State Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis Welty		M.D. WELTY JR		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 7-14-68	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 17		23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE		23d. LOCATION (City or Town) (County) (State) STEVENSVILLE MD.	
24. FUNERAL DIRECTOR Edgar L. Howe - Church Hill, Md.				25a. REC'D BY REGISTRAR JUL 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-8. Page 5 may be retained for your files.

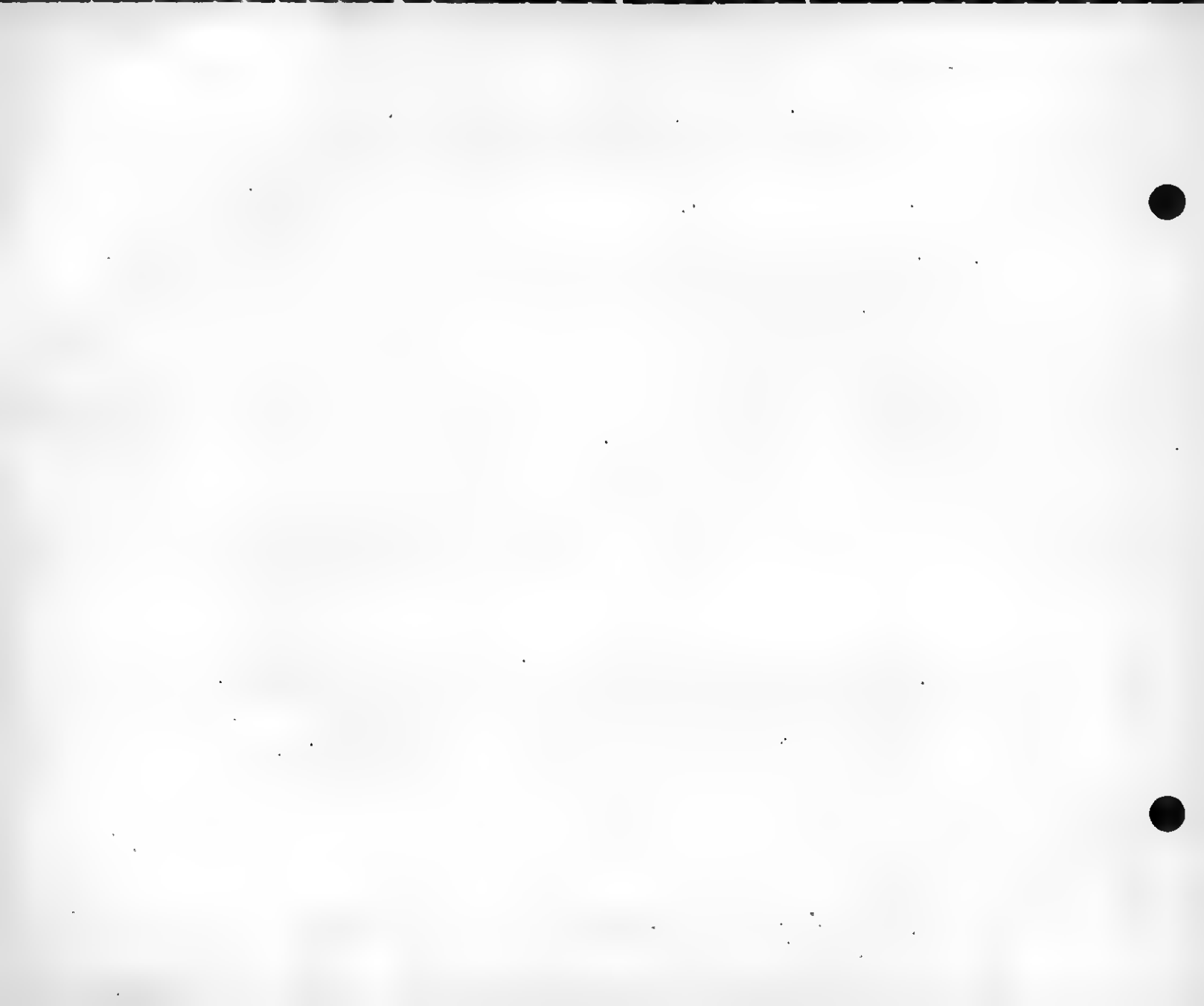
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH				2b HOUR	
Virgie Marie Darter						Month Day Year				8 5 16 8	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD				2d HOUR	
F	W	9-27-27	40 YRS	MONTHS	DAYS	Month Day Year				5 19 68	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
W. VA.		U.S.A.				Talbot					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			2b KIND OF BUSINESS OR INDUSTRY		
HARRISVILLE			EASTON MEMORIAL			HOME			HOUSEWIFE		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d STREET AND NUMBER		
MD.			A.A.			ANNAPOLIS			1155 MADISON ST.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
'UNK'			BESSIE WALKER								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No						JOSEPH M. DARTER #13					
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 812.1 Multiple Severe Injuries DUE TO, OR AS A CONSEQUENCE OF (b) Auto accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
										30 minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
116r											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
CE 8 PM 7-5 1968			7-5 1968			PASS IN TRUCK COLLISION					
21d INJURY OCCURRED			21e PLACE OF INJURY (At home, farm, street, factory, place building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			AT HOME			1155 Madison St			Talbot		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				M.D.		22b DATE SIGNED			
Leni J. Muty		WELTY JR						7-5-68			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County		State	
BURIAL		7-9-68		Arlington Nat'l		Arlington				VA.	
24 FUNERAL DIRECTOR						25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
John M. Taylor & Sons Annapolis, Md						JUL - 8 1968		J. Charles Judge			



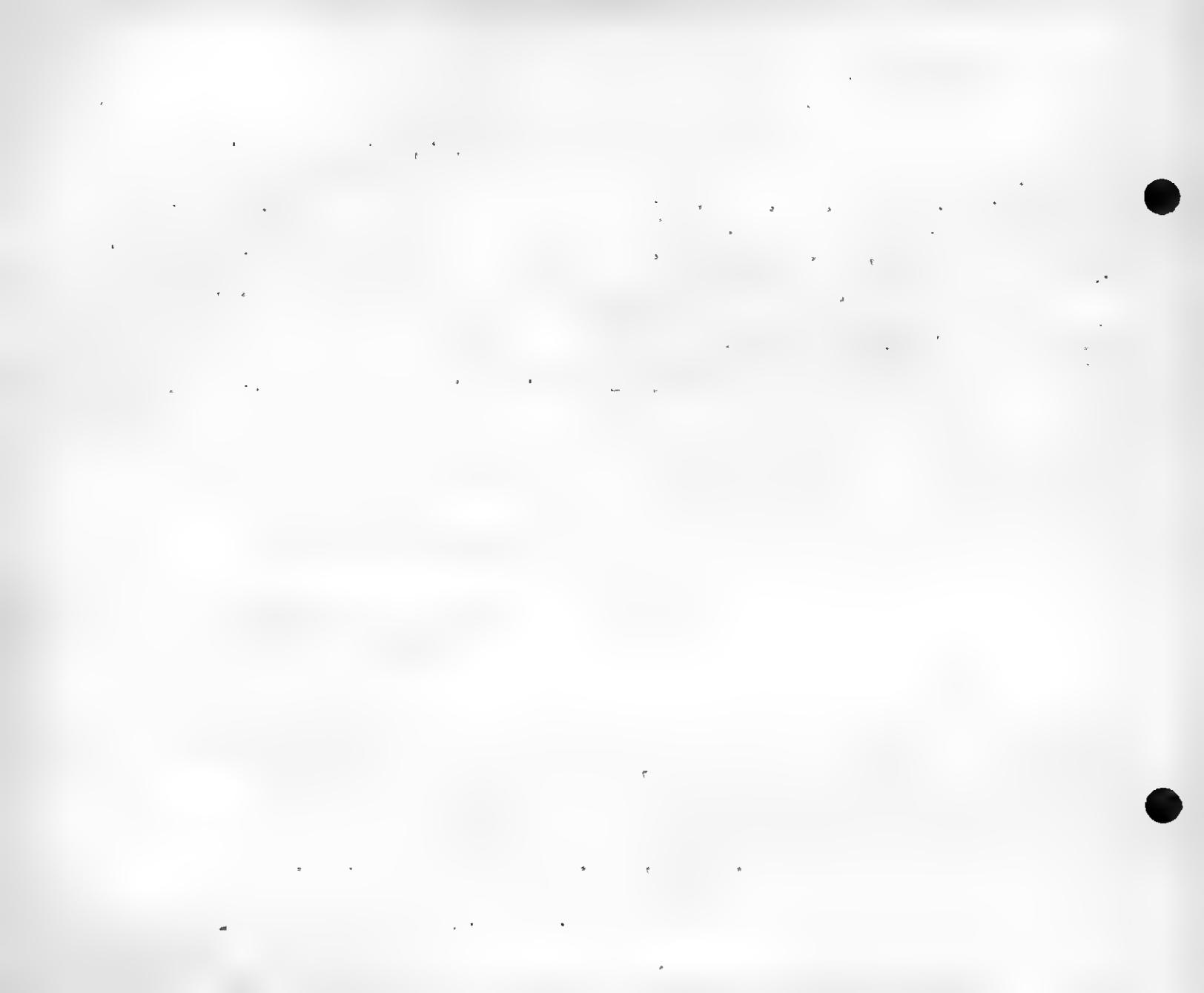
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Cora E. Donovan			2a DATE OF DEATH Month 7 Day 19 Year 68			2b HOUR 9:30 M			
3 SEX female		4 RACE white		5 DATE OF BIRTH Oct. 9, 1888		6 AGE (In years last birthday) 79 YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Caroline Co. Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.			
10 CITY OR TOWN OF DEATH Easton, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Lien. Hospital		12a USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Farm			
13a U.S. AL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.		13b COUNTY Caroline		13c CITY OR TOWN Denton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER RFD. 2	
14 FATHER'S NAME First Middle Last Charles W. Smith			15 MOTHER'S MAIDEN NAME First Middle Last Tamsey Jane Sullivan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b SOCIAL SECURITY NO 215-48-3789		17 INFORMANT Ruth D. Mitchell		Address Denton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF UNKNOWN SITE 1971 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) ?								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 1972 None									
19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from July 9, 1968 , to July 19, 1968 , that (I) (we) last saw the deceased alive on July 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dorsett D. Smith, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/2/68			
22d PHYSICIAN'S NAME (Type) Dorsett D. Smith, M.D.				22e ADDRESS Easton, Md. 21601					
23a B. RIAL CREMATION, REMOVAL (Specify)		23b DATE 7-21-68		23c NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d LOCATION (City or Town) (County) (State) Federalburg, Md.			
24. FUNERAL DIRECTOR Harvey Williamson				ADDRESS Federalburg, Md.		25a REC'D BY REGISTRAR JUL 24 1968		25b. REG. CLERK'S SIGNATURE Charles Judge	

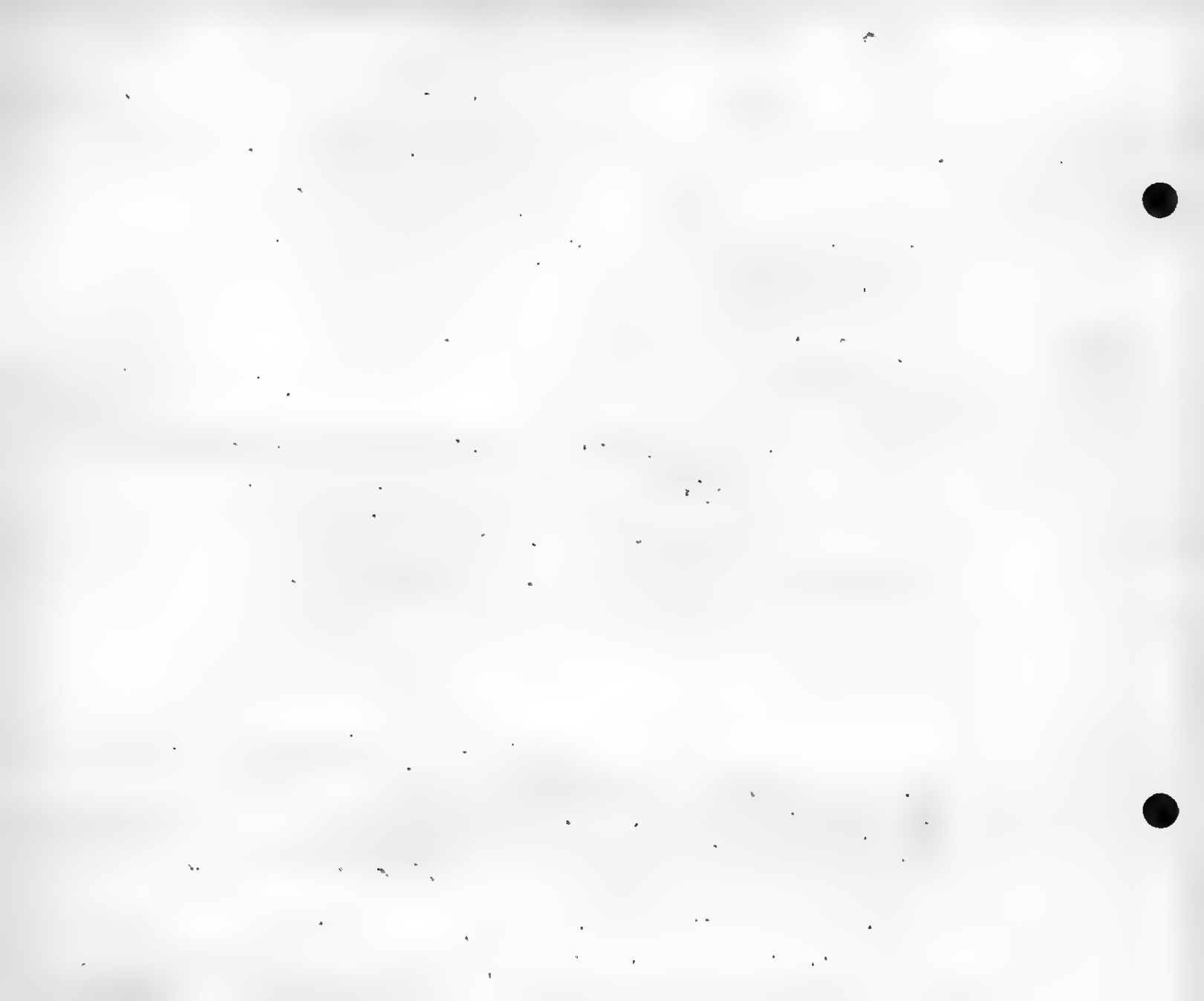


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) FLORENCE First Middle Last			2a. DATE OF DEATH Month July Day 7 Year 1968			2b. HOUR 8 P.M.	
3 SEX F		4 RACE W		5 DATE OF BIRTH JULY 27, 1887		6 AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) DEL.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH JALBOT Md	
10. CITY OR TOWN OF DEATH ST MICHAELS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RIO VISTA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) at home		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY CAROLINE		13c. CITY OR TOWN RODERLY		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last EDWARD H. ROE		15. MOTHER'S MAIDEN NAME First Middle Last LIZZIE LEWIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT JOS. WILLIAMS, 66 W. MARSHALL Rd.		Address LANSDOWN PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident							hours
DUE TO, OR AS A CONSEQUENCE OF atherosclerotic cerebro							
DUE TO, OR AS A CONSEQUENCE OF cardio vas d.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 (a) advanced senile changes							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased, from 10-2 , 19 67 , to 7-7 , 19 68 , that (I) (we) last saw the deceased alive on 7-7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wm M Reeser MD				22c. DATE SIGNED 7-9-68			
22d. PHYSICIAN'S NAME (Type) Wm M Reeser Jr				22e. ADDRESS St Michaels Md			
23a. BURIAL CREMATION, REMOVAL (Type)		23b. DATE July 11, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City or Town) (County) (State) DENTON CDE. MD.	
24. FUNERAL DIRECTOR CHARLES MOORE DENTON				25a. REC'D BY REGISTRAR JUL 31 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) ELNORA M. Gibson						2a. DATE OF DEATH Month 7 Day 13 Year 68			2b. HOUR 9:30 M			
3 SEX FEMALE		RACE COLORED		5. DATE OF BIRTH JAN. 15 1911			6 AGE (In years last birthday) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Talbot Co.			Md			
10 CITY OR TOWN OF DEATH EASTON, Md			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABOR			12b KIND OF BUSINESS OR INDUSTRY VARIOUS			
13a USUAL RESIDENCE (Where deceased lived, if institut an admission) STATE MD			13b COUNTY D.A. Co.		13c CITY OR TOWN CENTREVILLE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER R. G. D			
14 FATHER'S NAME First Richard Middle Smith Last Smith				15. MOTHER'S MAIDEN NAME First JULIA Middle KILSON Last KILSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b SOCIAL SECURITY NO. 216-18-8487		17. INFORMANT MRS DOBOTHY WRIGHT			Address CENTREVILLE, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cerebral thrombosis												
DUE TO, OR AS A CONSEQUENCE OF												
(b) 4357												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Alcoholic hepatitis												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 8 July 1968 , to 13 July 1968 , that (I) (we) last saw the deceased alive on 13 July 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE HURSTON HARRISON M.D.						DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 15 July 68			
22d. PHYSICIAN'S NAME (Type) HURSTON HARRISON						22e ADDRESS Easton, Maryland						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 7/16/1968		23c. NAME OF CEMETERY OR CREMATORY Chester F. Eld Cem.			23d. LOCATION (City or Town) (County) (State) CENTREVILLE D.A. Md				
24. FUNERAL DIRECTOR Ernest Waller Chester Town, Md						25a. REC'D BY REGISTRAR JUL 18 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) ELSIE			First Middle Last GLENN			2a. DATE OF DEATH Month Day Year 7 12 68			2b. HOUR P 4:00 M		
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-13-1896		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) CHESTERTOWN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.					
1d. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HO SE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY X					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) MARYLAND		13b. COUNTY KENT		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER XX					
14. FATHER'S NAME First Middle Last JAMES COLEMAN			15. MOTHER'S MAIDEN NAME First Middle Last DRUSCILLA GODFREY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Address SEdGAR GLENN - Rock Hall Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Uremia 5700 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 3-13-68 , 19__, to 7-12-68 , 19__, that (I) (we) last saw the deceased alive on 7-11-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen P. Carnes				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Stephen P. Carnes, M.D.				22c. DATE SIGNED 7-15-68							
22e. ADDRESS P.O. Box 929, Easton, Md. 21601											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JULY 15		23c. NAME OF CEMETERY OR CREMATORY Wesley CHAPEL		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		JULY 15		Wesley CHAPEL		Rock Hall		Kent		Md.	
24. FUNERAL DIRECTOR Edgar L. Harris				ADDRESS Church Hill, Md.		25a. REC'D BY REGISTRAR JUL 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

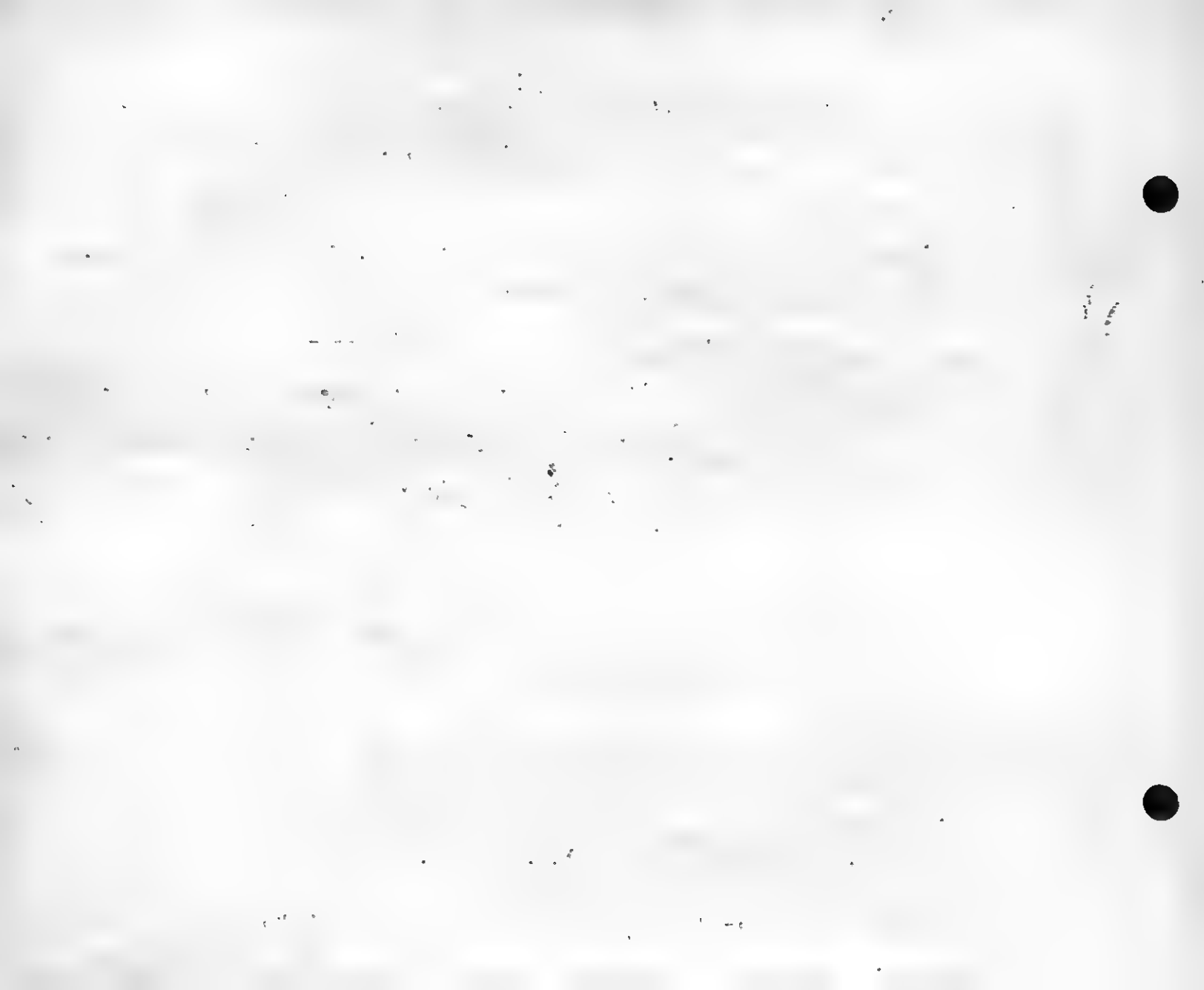
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2, 3, 4, and 5, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) HENRY JOSEPH GRANGE						2a. DATE OF DEATH Month 7 Day 27 Year 68			2b. HOUR 2:45 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 18, 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH Boston		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Bozman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ----			
14. FATHER'S NAME First Middle Last Peter Grange				15. MOTHER'S MAIDEN NAME First Middle Last Veronica -----							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 578-14-3368A		17. INFORMANT Address Mrs. Elsie S. Grange, Bozman, Maryland 21612							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 3 days 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis 4 days DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis 5 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 25 July, 1968 to 27 July, 1968 , that (I) (we) last saw the deceased alive on 27 July, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE R. Lane Wroth, MD		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-29-68					
22d. PHYSICIAN'S NAME (Type) R. Lane Wroth		ADDRESS M.D.		22e. ADDRESS St. Michaels, Maryland		22f. ADDRESS 7/29/68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Boston, Talbot, Maryland					
24. FUNERAL DIRECTOR Harrison E. Leonard		ADDRESS St. Michaels, Md.		25a. REC'D BY REGISTRAR Jul 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First Paul		Middle D		Last GRAY		2a DATE KNOWN OF DEATH Month 7 Day 3 Year 1968		2b HOUR M 1 P 38	
3 SEX male		4 RACE white		5 DATE OF BIRTH 5-8-44		6 AGE (In years) 24		7c DATE PRONOUNCED DEAD Month 7 Day 3 Year 1968		2d HOUR M 1 P 38	
7a BIRTHPLACE (State or foreign) BOONVILLE		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Tribot					
10. CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK DRIVER		12b KIND OF BUSINESS OR INDUSTRY SAME					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b COUNTY Wicomico		13c CITY OR TOWN Pittsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER RD2			
14. FATHER'S NAME First DAVID		Middle GRAY		Last NETTIE		15 MOTHER'S MAIDEN NAME First NETTIE		Middle HORNER		Last HORNER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. 214-42-8185		17 INFORMANT Mrs. PAUL D. GRAY		ADDRESS PITTSVILLE MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Severe Injuries DUE TO, OR AS A CONSEQUENCE OF (b) Truck accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7160											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 6 PM 7-2-68 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) driver of truck in collision with another			
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) highway				21f LOCATION Street or RFD No. City or Town County State Shopping Center nr Stevensville QA Md			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Louis J. Welty				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 7-3-68			
EXAMINER'S NAME (Type) Welty				MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				for DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)											
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b DATE 7/6/68		23c NAME OF CEMETERY OR CREMATORY FARLOW'S		23d LOCATION (City or Town) (County) (State) PITTSVILLE Wic MD			
24 FUNERAL DIRECTOR Anna A. Burbridge				ADDRESS Bellevue Md		25a REC'D BY REGISTRAR JUL - 8 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			



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VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <i>Anna Rebecca Green</i>			2a DATE OF DEATH Month Day Year <i>7 7 68</i>			2b HOUR MIN <i>4:20</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>9-1-82</i>		6 AGE (in years last birthday) YRS <i>75</i>		7 UNDER 1 YEAR IF UNDER 1 YRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>TALBOT</i>			
10 CITY OR TOWN OF DEATH <i>EASTON, MD</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>		13b COUNTY <i>QUEEN ANNE CENTREVILLE</i>		13c CITY OR TOWN <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>		13e STREET AND NUMBER <i>204 KIDWELL AVE</i>			
14 FATHER'S NAME First Middle Last <i>THOMAS J. MARK</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>MARY ANN WALBERTS</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b SOCIAL SECURITY NO.		17 INFORMANT <i>WM. GREEN - CENTREVILLE MD.</i>		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary emboli</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>thrombosis femoral veins</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>1 year</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>2311x</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTROLLING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that <i>Dr.</i> (this hospital), attended the deceased from <i>July</i> , 19 <i>68</i> , to <i>July</i> , 19 <i>68</i> , that <i>he</i> (we) last saw the deceased alive on <i>July</i> , 19 <i>68</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>he</i> (we) (did) (did not) view the body after death									
22b SIGNATURE <i>William P. Latimer M.D.</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED <i>July 7 68</i>			
22d PHYSICIAN'S NAME (Type) <i>WILLIAM LATIMER M.D.</i>				22e ADDRESS <i>EASTON, MARYLAND</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>JULY 3</i>		23c NAME OF CEMETERY OR CREMATORY <i>CHESTERFIELD</i>		23d LOCATION (City or Town) (County) (State) <i>CENTREVILLE G.A. MD.</i>			
24 FUNERAL DIRECTOR <i>Fitgerald & Sons, Church Hill, Md.</i>				25a REC'D BY REGISTRAR <i>JUL - 5 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) <i>Wm. Lee Douglas Greene</i>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>7</i> Day <i>20</i> Year <i>1968</i>			2b HOUR <i>M</i>			
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Apr 23 '68</i>	6 AGE in years last birthday <i>—</i> YRS	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HRS HOURS	9 MIN	2c DATE PRONOUNCED DEAD Month <i>7</i> Day <i>20</i> Year <i>1968</i>	2d HOUR <i>5:55</i>	
7a BIRTHPLACE (State or foreign country) <i>—</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>Easton</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Memorial</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>—</i>			13b COUNTY <i>—</i>		13c CITY OR TOWN <i>—</i>		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>1221 Carolina Drive</i>	
14 FATHER'S NAME First <i>—</i> Middle <i>—</i> Last <i>—</i>			15. MOTHER'S MAIDEN NAME First <i>—</i> Middle <i>—</i> Last <i>—</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO <i>—</i>		17 INFORMANT ADDRESS <i>Dr. Douglas Greene, 1221 Carolina Drive</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Crib death</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>795.5</i>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year <i>—</i> HOUR A.M. <i>—</i> P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Louis O. Neely</i>		EXAMINER'S NAME (Type) <i>WEKTV for</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county)		22b DATE SIGNED <i>7-21-68</i>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>July 23, 1968</i>		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
24 FUNERAL DIRECTOR <i>Howard K. McComas & Son, Inc.</i>		ADDRESS		25a REC'D BY REGISTRAR <i>JUL 23 1968</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10650

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9, Film 3403 8/5/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) Randol			First Middle Last			2a DATE KNOWN OF DEATH MATED <input type="checkbox"/> 7/24 1968			2b HOUR 2 P M				
3. SEX M		4 RACE C		5 DATE OF BIRTH 8-18-05		6 AGE (in years last birthday) 62 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TALBOT			
10 CITY OR TOWN OF DEATH Spartan				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Fla				13b COUNTY Pinellas Beach				13c CITY OR TOWN Pinellas		13d INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1610 NW 22 ST / Tula	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT ADDRESS add.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stab wound chest = Left Jugular Artery													
DUE TO, OR AS A CONSEQUENCE OF (b) Scrubbing + Shaver													
DUE TO, OR AS A CONSEQUENCE OF (c) Cutting Left Jugular Artery													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pt. SE. Fla. TB. Hosp. 1968 (3-12)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b TIME OF INJURY Month, Day Year 7-24 1968				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Stabbed in chest					
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home Slump. W. Federalsburg				21f LOCATION (Street or RFD No City or Town County State) Caroline Del					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> ; Accident <input type="checkbox"/> ; Suicide <input type="checkbox"/> ; Homicide <input checked="" type="checkbox"/> ; Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Harold B. Plummer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 7/24/68					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town or county) Parton, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE 7-26-68				23c NAME OF CEMETERY OR CREMATORY V. of Ind. Med. School					
				23d LOCATION (City or Town) (County) (State) Baltimore Md.									
24 FUNERAL DIRECTOR Funeral Home				25a REC'D BY REGISTRAR St. Michael				25b REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH ESTIMATED	
EMERSON				Griffin				Month 7 Day 23 Year 1968	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (if years last birthday)	7 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	Negro	7-16-1929		29	MONTHS DAYS HOURS MIN	Month 7 Day 23 Year 1968		11:35 P.M.	
7a. BIRTHPLACE (State or foreign)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Elizabeth City, N. Car		United States		NEVER MARRIED		Caroline		Talbot	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Emmorial Hospital		Laborer		Milk Industry			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before death)		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET AND NUMBER	
Maryland		Caroline		Denton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		North 5th Street	
14. FATHER'S NAME		15. MOTHER'S M A D E N NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		ADDRESS	
Eugene Begues		Tinney Griffin		No		Officer Roger Schofield		Denton Police	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		b. Rupture of arch of Aorta		c. Rupture of left radial artery		d. Stab wounds by Butcher Knife	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		Shock from Exsanguination		minutes		minutes		minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Possible alcohol blood specimen destroyed by fire. 1 attendant							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. NATURE OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)	
11:25 PM 7/23/68		Stabbed by lady friend		Denton North Caroline					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		ASS STANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER	
ACTUAL SIGNATURE		H. B. Plummer		M.D.		7/23/68		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		H. B. PLUMMER, M.D.		ADDRESS (Street city town, or county)		Inston Caroline			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-23-1968		Robinson's Semetary		Elizabeth City, N. Carolina			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles W. Hill, Mortician, Denton, Md.				JUL 29 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
George			C Griffin Jr.			July 3 1968			7:45 P.M.
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE in years last birthday		IF UNDER 1 YEAR IF UNDER 1 MRS.	
Male	Negro		10-30-02			65 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				TALBOT Md.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton			Memorial Hosp			CARE TAKER		NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			QUEEN ANNE		QUEENSTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RURAL
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
GEORGE GRIFFIN			KATIE RALEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
NO			213-22-8934		MARY GRIFFIN, QUEENSTOWN, MARYLAND				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal comminatio									2 months
174.0 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1912									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Chronic symptomatic leukemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 1968, to July 3 1968, that (I) (we) last saw the deceased alive on 3 July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (that) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Stephen P. Carney					M.D.		7-5-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		Easton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		7-8-68		METROPOLITAN		GOLDTOWN QUEEN ANNE MARYLAND			
24 FUNERAL DIRECTOR		ADDRESS		JUL 8 1968		REGISTERED SIGNATURE			
B. E. Darshell		426 DOVER ST EASTON, MD. 21601				JUL 8 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) LORENZO ^{First} GRIFFIN ^{Last}						2a. DATE OF DEATH 7 Month - 2 Day - Year 68			2b. HOUR 1:25 PM		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH Jan. 1 - 1900		6. AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.					
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) McGowan Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) laborer			12b. KIND OF BUSINESS OR INDUSTRY Barber's		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Queen Anne's			13c. CITY OR TOWN Queenstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route #1 Box 48	
14. FATHER'S NAME First Middle Last Rosell Griffin				15. MOTHER'S MAIDEN NAME First Middle Last Rachel Nutchin							
16a. WAS DECEASED EVER IN U.S. ARMY FORCES? Yes (If yes give year or dates of service) 8/22/42 - 12/1/46				16b. SOCIAL SECURITY NO 25-20-0269		17. INFORMANT Address Florence E. Griffin					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Diverticulus DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day 4 day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that the (this hospital) attended the deceased from _____, 19____, to _____, 19____, that the (we) lost saw the deceased alive on 2 July 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, the (we) (did) (did not) view the body after death.											
22b. SIGNATURE WE Palmer MD						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 2 July '68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/6/68		23c. NAME OF CEMETERY OR CREMATORY Cornmeal Cem			23d. LOCATION (City or Town) (County) (State) Cornmeal MD Md				
24. FUNERAL DIRECTOR George H Washfield						25a. REC'D BY REGISTRAR DATE JUL - 8 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR	
O. AUGUSTA GRIFFITH						7. 13 1968			M	
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS.
F	W		OCT 25 1877			70 YRS		MONTHS	DAYS	HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Md		U.S.A.				TALBOT Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
ST. MICHAELS			RIVISTA NURSING			HOUSEKEEPER			OWN HOME	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND			TALBOT		TUNIS MILLS					
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last	
THOMAS FRANCIS GRIFFITH						EUPHEMIA			HILL	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address	
No						MRS EVELYN T. ORME			DENTON, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> 4 X C X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>arteriosclerosis. Fractured hip</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>30 Dec.</u> , 19 <u>67</u> , to <u>13 July</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>8 July</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Stephen P. Carney</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 7-15-68				
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.				22e ADDRESS P.O. Box 929, Easton, Md. 21601						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
		7-16-68		SPRING HILL			EASTON TALBOT MD			
24 FUNERAL DIRECTOR <u>Rea Hunt</u>				ADDRESS <u>Easton, Md</u>		25a. REC'D BY REGISTRAR JUL 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return~~ ^{send} one carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

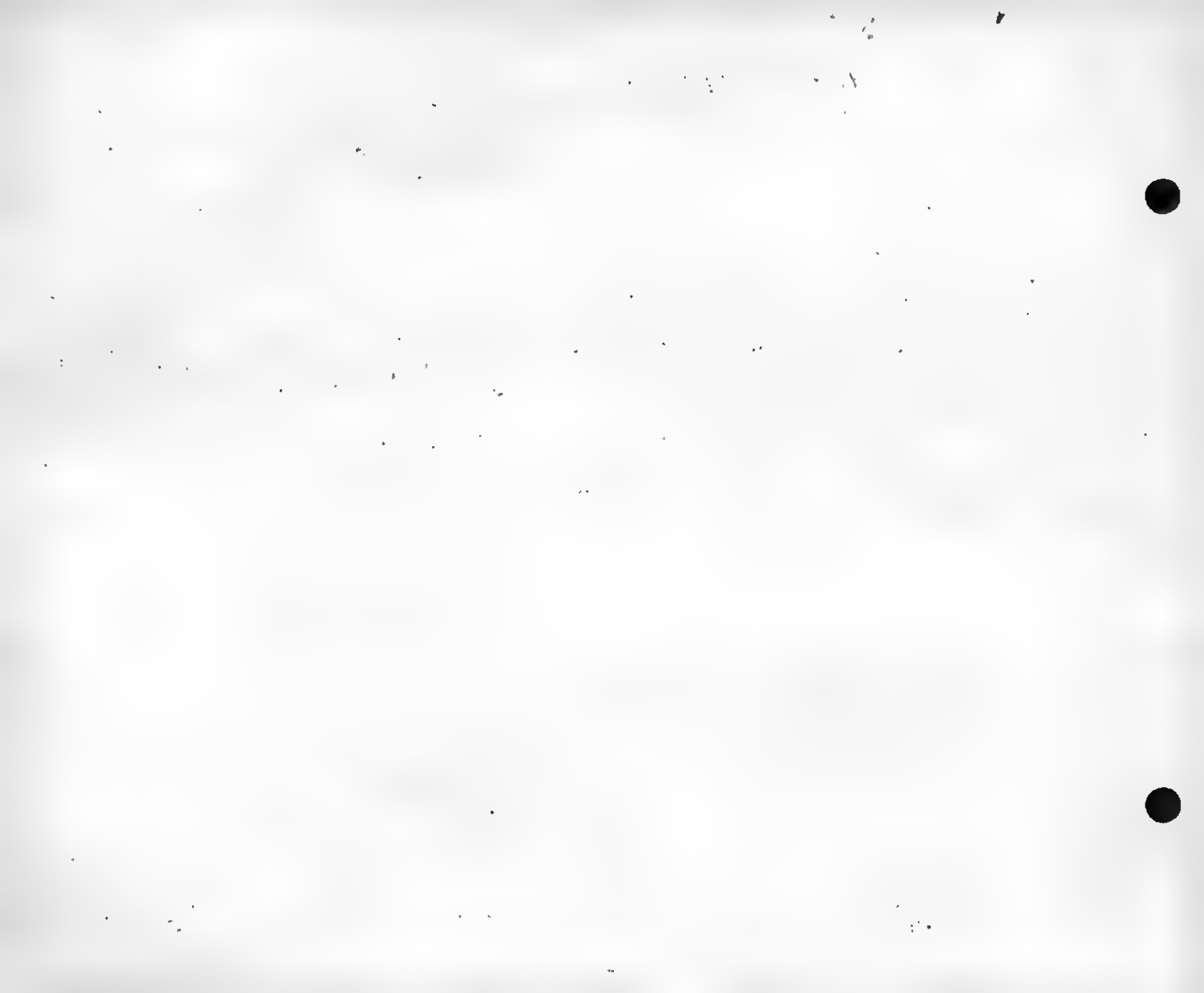
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30M REV 1/68

1948

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) LARA Michelle Baby Girl Hammond		Last		2a DATE OF DEATH Month July Day 28 Year 1968		2b HOUR 2:54 M	
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH July 26, 1968		6 AGE (in years last birthday) YRS 2 MONTHS 2 DAYS 2 HOURS 2 MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md	
10. CITY OR TOWN OF DEATH Crofton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY QUEEN ANNES CENTREVILLE		13c CITY OR TOWN Centreville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 102 Price Street		14 FATHER'S NAME First Middle Last Carroll Benjamin Hammond Jr		15. MOTHER'S MAIDEN NAME First Middle Last Lauren Lana Pierson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. None		17 INFORMANT FATHER Carroll B. Hammond, Jr		Address 102 Price St. Centreville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W E Salmer MD		22c. PHYSICIAN'S NAME (Type) Pathologist		22e. ADDRESS		22d. DATE SIGNED 29 July 1968	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE July 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION (City or Town) (County) (State) CENTREVILLE QUEEN ANNES, Md.	
24. FUNERAL DIRECTOR James H. Baitinger-Baitinger Bros		ADDRESS Centreville, Md.		25a. REC'D BY REGISTRAR DATE JUL 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Aubrey BARTLETT HARRIS			2a. DATE OF DEATH Month 7 Day 5 Year 68			2b. HOUR 1:18 PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH APRIL 21, 1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) SEAFOOD PACKER		12b. KIND OF BUSINESS OR INDUSTRY RETIRED			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN OXFORD		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER MORRIS STREET	
14. FATHER'S NAME First Middle Last WILLIAM T. HARRIS			15. MOTHER'S MAIDEN NAME First Middle Last EMMA BARTLETT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 215-38-1415		17. INFORMANT Address MRS. AUBREY B. HARRIS OXFORD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Bronchopneumonia									
19a. DATE OF OPERATION NONE.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 2nd, 1968 to July 5th, 1968 , that (I) (we) lost the deceased alive on July 5th, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. R. W. Bain MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/5/68			
22d. PHYSICIAN'S NAME (Type) C. R. W. BAIN				22e. ADDRESS 210 E. DOVER, EASTON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JULY 8, 1968		23c. NAME OF CEMETERY OR CREMATORY SPRING HILL		23d. LOCATION (City or Town) (County) (State) EASTON TALBOT MD.			
24. FUNERAL DIRECTOR W. J. ...				25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

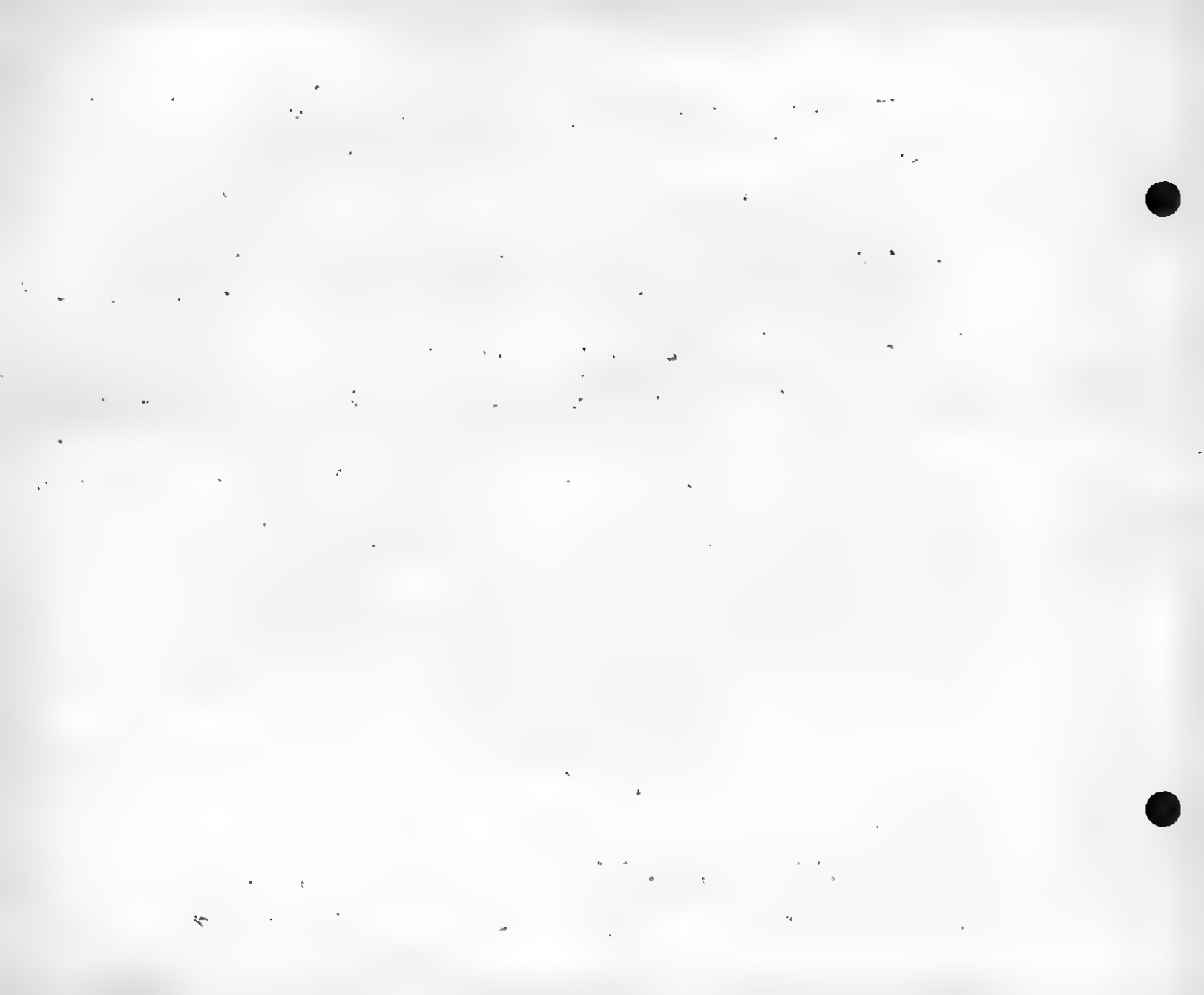


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Thomas Burke Haskins			2a. DATE OF DEATH Month Day Year July 18 1968			2b. HOUR 3:30 PM			
3. SEX male		4. RACE Negro		5. DATE OF BIRTH 6-30-93		6. AGE (In years last birthday) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) water man		12b. KIND OF BUSINESS OR INDUSTRY fisherman			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Talbot		13c. CITY OR TOWN Bellevue		13d. INSIDE CITY LMA 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 12 - Bellevue Md	
14. FATHER'S NAME First Middle Last George W Haskins			15. MOTHER'S MAIDEN NAME First Middle Last Leah C Burke						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 216-149104		17. INFORMANT BESSIE BRYCE		Address Bellevue Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Myocardial Infarction 15 min (b) Ruptured Heart 1 hour (c) Septicemic Cardiovascular 20 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 420									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I (this hospital) attended the deceased from 7:15, 1968, to 7:18, 1968, that I (we) last saw the deceased alive, on 18 July, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Lane Wroth, M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-19-68			
22d. PHYSICIAN'S NAME (Type) St. Michaels, Md.		22e. ADDRESS St. Michaels, Md. 21663							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/30/68		23c. NAME OF CEMETERY OR CREMATORY Richmonds		23d. LOCATION (City or Town) Easton		(County) (State) Md	
24. FUNERAL DIRECTOR George N. Doherty		ADDRESS Easton Md		25a. REC'D BY REGISTRAR JUL 24 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

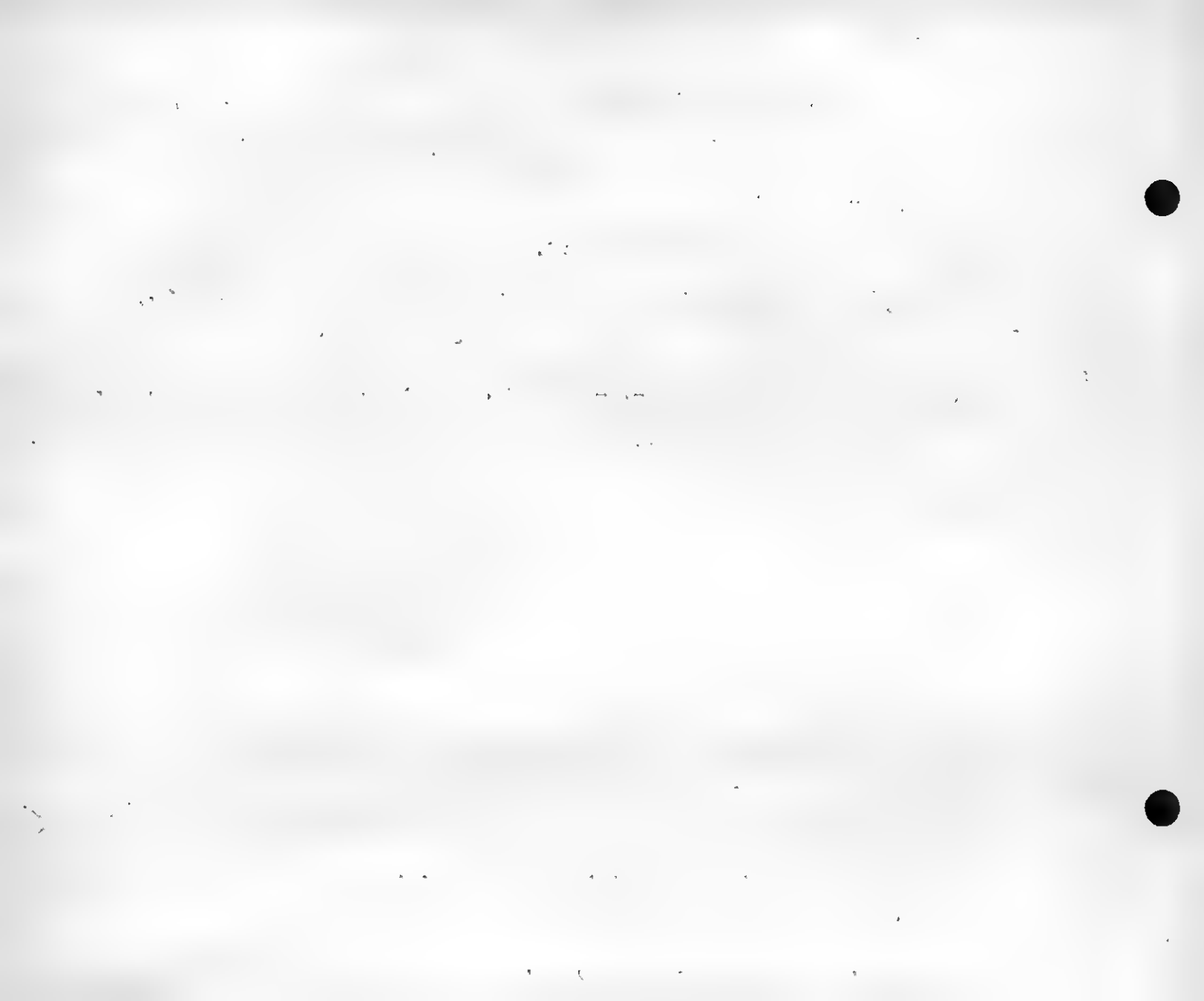
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Ida			Middle Ellen			Last Kemp		
2a DATE KNOWN OF DEATH			Month <input type="checkbox"/> 7 Day <input type="checkbox"/> 25 Year <input type="checkbox"/> 1968			2b HOUR			M		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)		
Female			White			8-19-1895			72 YRS		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Delaware			U.S.A.						Talbot		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hospital			Housewife			None		
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b CITY OR TOWN			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Caroline			Greensboro			School Street		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
?			Thorp			No Record					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			222-14-7357			Elsie Cain Marydel, Delaware					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>347.1</u> <u>Advanced emphysema producing anoxia of brain</u>										3 days	
Condit ions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) <u>Marked brain atrophy</u>										?	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Chronic passive congestion of liver and spleen</u>										?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Generalized arteriosclerosis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED		
<u>Harold B. Plummer</u>			M.D.						7/27/68		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			Preston Caroline		
Harold B. Plummer											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7-28-68			Greensboro,			Greensboro, Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
<u>E. Bouleis</u>			Greensboro, Md.			DATE JUL 31 1968			<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Horace Greeley Kennedy</i>						2a DATE OF DEATH <i>7</i> Month <i>28</i> Day <i>1968</i> Year			2b. HOUR <i>M</i>		
3. SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>9/25/1897</i>			6 AGE (In years last birthday) <i>70</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md					
10 CITY OR TOWN OF DEATH <i>Trappe</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>21 Maple Ave.</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <i>Maryland</i> STATE		13b. COUNTY <i>Talbot</i>		13c CITY OR TOWN <i>Trappe</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>21 Maple Ave.,</i>			
14 FATHER'S NAME First <i>Peter Kennedy</i> Middle Last				15 MOTHER'S MAIDEN NAME First <i>Martha Blades</i> Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <i>218-16-6002</i>		17 INFORMANT Address <i>Mrs. Horace G. Kennedy, Trappe, Md.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>65</i> , to <i>July</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12 June 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Stephen P. Carney</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c DATE SIGNED <i>7-29-68</i>					
22d PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M.D.</i>						22e ADDRESS <i>P.O. Box 929, Easton, Md. 21601</i>					
23a. BURIAL, CREMATION, REMOVAL <i>burial</i>		23b. DATE <i>7/30/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mundy Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Trappe, Md</i>					
24 FUNERAL DIRECTOR ADDRESS <i>MURICE E. NEUNAM & SON, Easton, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>JUL 30 1968</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

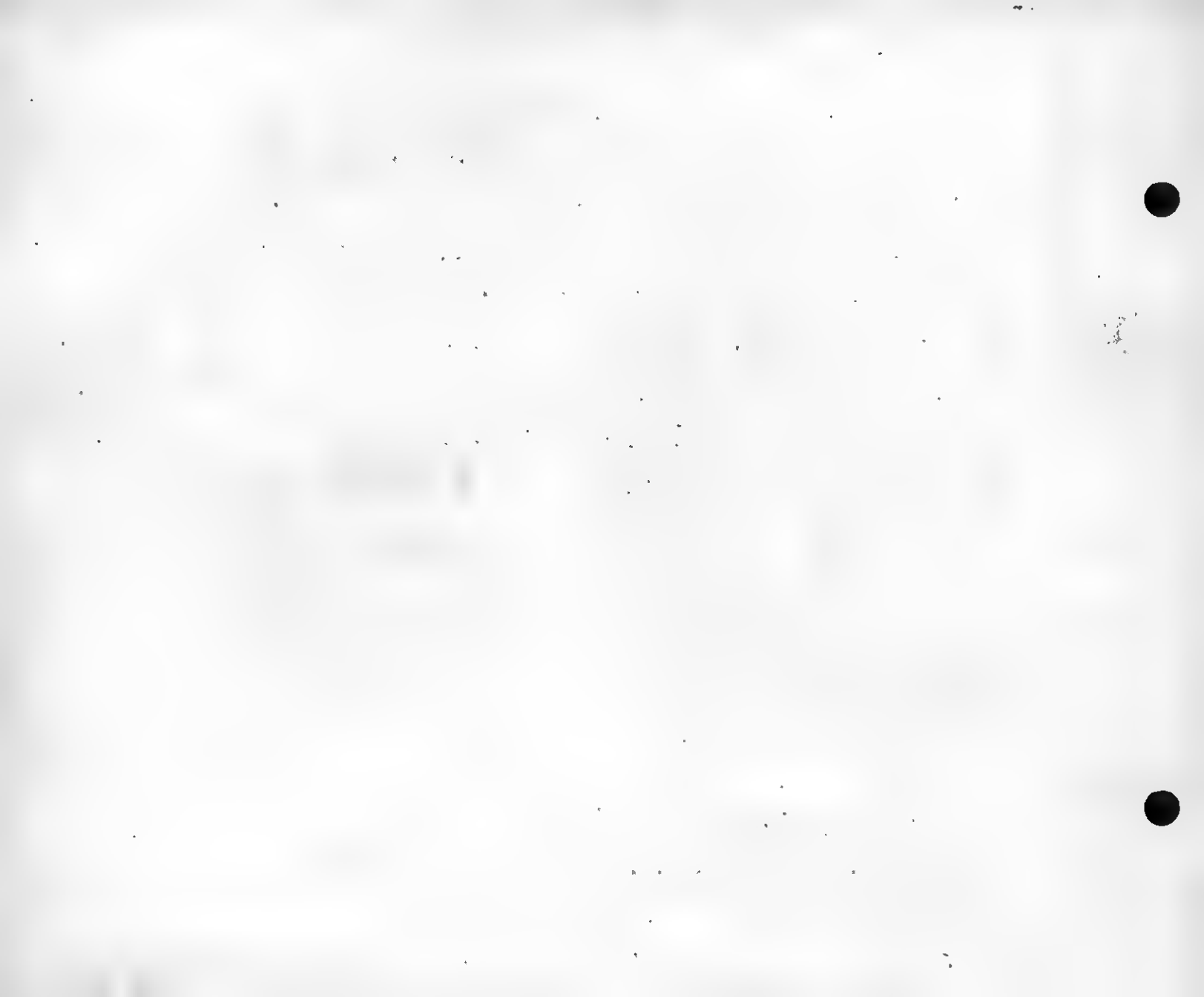


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>ELLA H LANK-FORD</i>			2a. DATE OF DEATH 7 Month 25 Year 68			2b. HOUR 1:45 PM			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Aug. 12, 1896		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN McDaniel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rural	
14. FATHER'S NAME First Middle Last Henry D. Hopkins			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Dennis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 213 09 4868A		17. INFORMANT Address Dorothy Caldwell, McDaniels, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral Thrombosis</i> <i>Septicemia</i> <i>Cerebral Vascular Disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>15 July 1968</i> to <i>25 July 1968</i> , that (I) (we) saw the deceased alive on <i>15 July 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. Lane Wroth, M.D.</i>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-26-68	
22d. PHYSICIAN'S NAME (Type) R. Lane Wroth, M.D.				22e. ADDRESS St. Michaels, Md. 21663					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7/27/68		23c. NAME OF CEMETERY OR CREMATORY Wesley Church		23d. LOCATION (City or Town) (County) (State) Marion, Somerset Md.			
24. FUNERAL DIRECTOR Mrs. J. B. Washell				ADDRESS 426 <i>Easton, Md.</i> <i>Dorchester St.</i>		25a. REC'D BY REGISTRAR DATE JUL 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or Print) <i>Mildred Howard Leitch</i>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>7</i> Day <i>5</i> Year <i>1968</i>			2b HOUR <i>8 AM</i>		
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>4-6-1924</i>	6 AGE (In years last birthday) <i>44</i> YRS	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	2c DATE PRONOUNCED DEAD Month <i>7</i> Day <i>5</i> Year <i>1968</i>		2d HOUR <i>M</i>
7a BIRTHPLACE (State or foreign country) <i>Ky.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Talbot</i>		
10 CITY OR TOWN OF DEATH <i>WYKE Mills</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rt. 50</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>TEACHING</i>		12b KIND OF BUSINESS OR INDUSTRY <i>TEACHER</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>MD.</i>		13b COUNTY <i>ANNAPOLIS</i>		13c CITY OR TOWN <i>ANNAPOLIS</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>810 TYLER AVE.</i>
14 FATHER'S NAME First <i>CLYDE</i> Middle <i>H.</i> Last <i>HOWARD</i>			15 MOTHER'S MAIDEN NAME First <i>Mallie</i> Middle <i>FEE</i> Last <i>FEE</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO <i></i>			17 INFORMANT <i>RONALD P. LEITCH</i>		ADDRESS <i>#13</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple severe injuries</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auto accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 HOURS</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2164</i>								
19a DATE OF OPERATION <i>7-5-68</i>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>7-5-1968</i> HOUR A.M. <i>7:55</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>PASS IN ROAD COLLISION</i>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Rt 50 + 404</i>		21f LOCATION Street or R.F.D. No <i>WYKE Mills</i> City or Town <i>Tal</i> County <i>MD</i> State <i>MD</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Louis J. Shetty</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>7-5-68</i>		
EXAMINER'S NAME (Type) <i>WELTY</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county) <i></i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>7-9-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN</i>		23d LOCATION (City or Town) (County) (State) <i>GLEN BUEVIE AP. MD.</i>		
24 FUNERAL DIRECTOR <i>John M. Lyle & Sons Annapolis, Md.</i>			25a REC'D BY REGISTRAR <i>JUL - 9 1968</i>			25b REGISTRAR'S SIGNATURE <i>John Charles Judge</i>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Pages 4 and 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First PAUL	Middle CATTERTON	Last LEITCH	2a DATE KNOWN OF DEATH: MATED <input checked="" type="checkbox"/> 7 5 68 19 68A M			2b HOUR
3 SEX male	4 RACE white	5 DATE OF BIRTH 10-26-22		6 AGE (in years last birthday) 45 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month 7 Day 5 Year 19 68 2d HOUR M	
7a BIRTHPLACE (State or foreign country) Md.		7b C T ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TALBOT		
10. CITY OR TOWN OF DEATH nr Wye Mills Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt 50			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SUPERVISOR		12b KIND OF BUSINESS OR INDUSTRY BOAT YARD	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b COUNTY AA ✓		13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 810 Tyler Ave
14 FATHER'S NAME First Middle Last BENJAMIN LEITCH		15 MOTHER'S MAIDEN NAME First Middle Last MARtha P. Catterton						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES		(If yes give year in military service) WWII		16b SOCIAL SECURITY NO.		17. INFORMANT RONALD P. LEITCH #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple severe injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7164								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year c 8A P.M. 7-5-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 2 car collision				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rte 50 & 404		21f LOCATION Street or R.F.D. No nr Wye Mills		City or Town County State Talbot Md		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Louis Welty			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> for DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 7-5-68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 7-9-68		23c NAME OF CEMETERY OR CREMATORY GLEN HAVEN		23d LOCATION (City or Town) (County) (State) GLEN BURNIE AA. MD.		
24. FUNERAL DIRECTOR John M. L. ... Annapolis, Md.				25a REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10643

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>Sue Ann Leitch</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>7</i> Day <i>5</i> Year <i>1968</i>			2b. HOUR <i>M</i>			
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>9-3-1957</i>	6 AGE (in years last birthday) <i>10</i> YRS	7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8 UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>7</i> Day <i>5</i> Year <i>1968</i>			
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>MEMORIAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>STUDENT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SCHOOL</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>A.A. Annapolis</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>810 TYLER AVE</i>	
14 FATHER'S NAME First <i>Paul</i> Middle <i>C.</i> Last <i>Leitch</i>			15. MOTHER'S MAIDEN NAME First <i>Mildred</i> Middle <i>Howard</i> Last <i>Howard</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO <i>1164</i>			17. INFORMANT <i>RONALD P. Leitch</i> ADDRESS <i>#13</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple severe injuries</i> <i>812.1</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auto accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <i>7-5-68</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year <i>7-5 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i>Pass in VCAV collision</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm street factory, office building, etc.) <i>Rt 50 + 404</i>		21f. LOCATION Street or RFD No <i>nr Wyemills</i> City or Town <i>Tal</i> County <i>md</i> State <i>md</i>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Louis O. Meltz</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MED CAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>7-5-68</i>			
EXAMINER'S NAME (Type) <i>LOUIS O. MELTZ</i>		ADDRESS (Street, city, town, or county) <i>MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>7-9-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN</i>		23d. LOCATION (City or Town) (County) (State) <i>GLEN BURNIE A.D. MD.</i>			
24. FUNERAL DIRECTOR <i>JOHN M. TAYLOR & SONS Annapolis, Md.</i>				25a. REC'D BY REGISTRAR <i>JUL - 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			Month	Day	Year	2b HOUR	
DAVID CHAPIN LITTLEWOOD						7-5-68			7	5	1968	1:20	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD			Month	Day	Year	2d HOUR	
male	white	Nov 20, 1950	17 YRS	MONTHS	DAYS	7-5-68			7	5	1968	M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md				
New York		USA				TALBOT							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Bastion			Memorial Hospital			Student			---				
13a USUAL RESIDENCE (Where deceased lived, if not institution - Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER	
Maryland			Talbot			St. Michaels			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			---	
14 FATHER'S NAME				First	Middle	Last	15 MOTHER'S MAIDEN NAME				First	Middle	Last
William C. Littlewood							Ruth Bosson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.		17 INFORMANT			Mantingham Farm				
NO				352-38-4582		William C. Littlewood, St. Michaels, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Perforating wound of heart</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Making home-made firecracker -which exploded prematurely</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
7-5-68													
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
c 12:30 A.M. 7-5-68			7-5-68			Homemade bomb exploded prematurely							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County State		
			home			RD St Michaels			Talbot		Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			M.D.			22b DATE SIGNED				
Louis J. Welty			Welty			f			7-5-68				
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County) (State)		
Cremation			July 6, 1968		Pt. Lincoln Cemetery			Washington, D. C.					
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Harison E. Leonard, St. Michaels, Md.			JUL - 8 1968			J Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) WARREN MILTON LOWERY			2a. DATE OF DEATH Month 7 Day 7 Year 1968			2b. HOUR 1:30 PM	
3 SEX MALE		4. RACE WHITE		5 DATE OF BIRTH 3/19/1899		6 AGE (In years last birthday) 69 YRS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a USUAL OCCUPATION (Kind at work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c CITY OR TOWN TILGHMAN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER							
14 FATHER'S NAME First JAMES Middle LOWERY Last			15 MOTHER'S MAIDEN NAME First ALICE Middle COVINGTON Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO. 212-2-5339		17 INFORMANT Address MRS. W.M. LOWERY, TILGHMAN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 492X DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) COPD PATTERNS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 10 yrs 3 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 271 NONA							
19a DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/4 , 19 68 , to 7/7 , 19 68 , that (I) (we) last saw the deceased alive on 7/6/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Dorset D. Smith M.D.				22c. DATE SIGNED 7/7/68		22d. PHYSICIAN'S NAME (Type) DORSET D. SMITH M.D.	
22e. ADDRESS 202 E. DAVEN ST. EASTON							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 7/9/1968		23c NAME OF CEMETERY OR CREMATORY METHODIST		23d LOCATION (City or Town) (County) (State) TILGHMAN, MD	
24 FUNERAL DIRECTOR Maurice A. Derramae Jr. Easton, Md.		25a REC'D BY REGISTRAR JUL 10 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) HERMAN M MARSHALL			2a DATE OF DEATH Month 7 Day 16 Year 1968			2b HOUR 4A.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MAR. 28, 1894		6 AGE (In years lost birthday) 74 YRS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN WITTMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER ---		14 FATHER'S NAME First Middle Last CHARLES MARSHALL		15. MOTHER'S MAIDEN NAME First Middle Last KATE SCHELLS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No		16b SOCIAL SECURITY NO 212-18-5915		17 INFORMANT CLARENCE MARSHALL MD.		Address WITTMAN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic carcinoma DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) cachexia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1953 , 19____, to 7-16 , 19 68 , that (I) (we) last saw the deceased alive on 7-16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Wm M Creech MD		22c DATE SIGNED 7-22-68		22d PHYSICIAN'S NAME (Type) Wm M Creech Jr			
22e ADDRESS St. Michaels Md		22f. LOCATION (City or Town) (County) (State) St. Michaels, Talbot Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 19, 1968		23c NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d LOCATION (City or Town) (County) (State) St. Michaels, Talbot Md.	
24 FUNERAL DIRECTOR Samson E. Leonard		24b ADDRESS St. Michaels Md		25a. REC'D BY REGISTRAR JUL 22 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

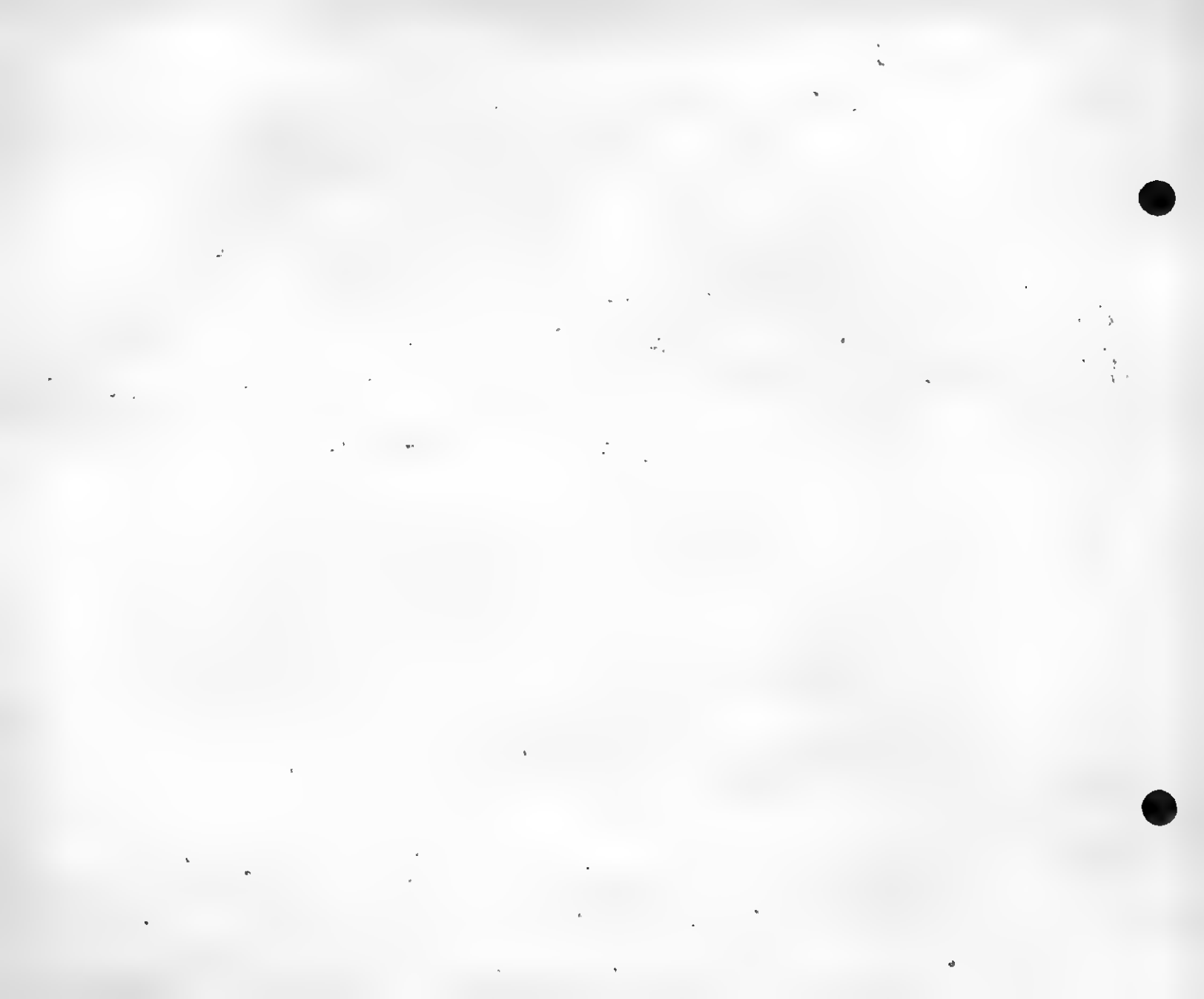
1 DECEASED-NAME (Type or print) <i>William Augustine Palmer</i>		2a. DATE OF DEATH Month <i>7</i> Day <i>27</i> Year <i>1968</i>		2b. HOUR <i>5:45</i> M	
3 SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5 DATE OF BIRTH <i>AUG. 12 - 1888</i>	
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <i>Easton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>FARMER</i>	
13a. USUAL RESIDENCE (Where deceased lived, if inst tut on. Res dence before admission) STATE <i>MARYLAND</i> COUNTY <i>QUEEN ANNE CHESTER</i>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c STREET AND NUMBER <i>XX</i>	
14 FATHER'S NAME First <i>EDMUND B.</i> Middle <i>PALMER</i> Last		15 MOTHER'S MAIDEN NAME First <i>FANNIE E.</i> Middle <i>CARMINE</i> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <i>220-34-7623</i>		17 INFORMANT Address <i>ARNOLD PALMER - CHESTER</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis - left</i> DUE TO, OR AS A CONSEQUENCE OF <i>hypertension</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>3222</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>7-27</i> , 19 <i>68</i> , to <i>27 July, 1968</i> , that (I) (we) last saw the deceased alive on <i>27 July</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thurston Harrison M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>27 July 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		22e. ADDRESS <i>Easton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>AUG. 1</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL</i>	
24. FUNERAL DIRECTOR <i>Edgar L. Harris</i>		23d. LOCATION (City or Town) (County) (State) <i>EASTON - MARYLAND</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>AUG 2 1968</i>			

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VR 5-5415
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR
SARAH EMILY PARKS						JULY 14 1968			M
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F	W		MAR. 31, 1877			97 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD		USA				TALBOT Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
TRAPPE						ST JAMES			
13a. USJA: RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		13e STREET AND NUMBER	
MD			CHARLOTTE DENTON			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JAMES IRELAND			SARAH FRAMPTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address				
NO					MARGARET NEWTON, DENTON				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4-44									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 18 June, 1968, to 19 June, 1968, that (I) (we) last saw the deceased alive on 22 June, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE Thornton Harrison M.D.					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 22 July 68		
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS				
THORNTON HARRISON					Coke Maryland				
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 22, 1968		DENTON		DENTON CARL MD			
24. FUNERAL DIRECTOR CHARLES MOORE DENTON, MD.					25a REC'D BY REGISTRAR DATE JUL 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

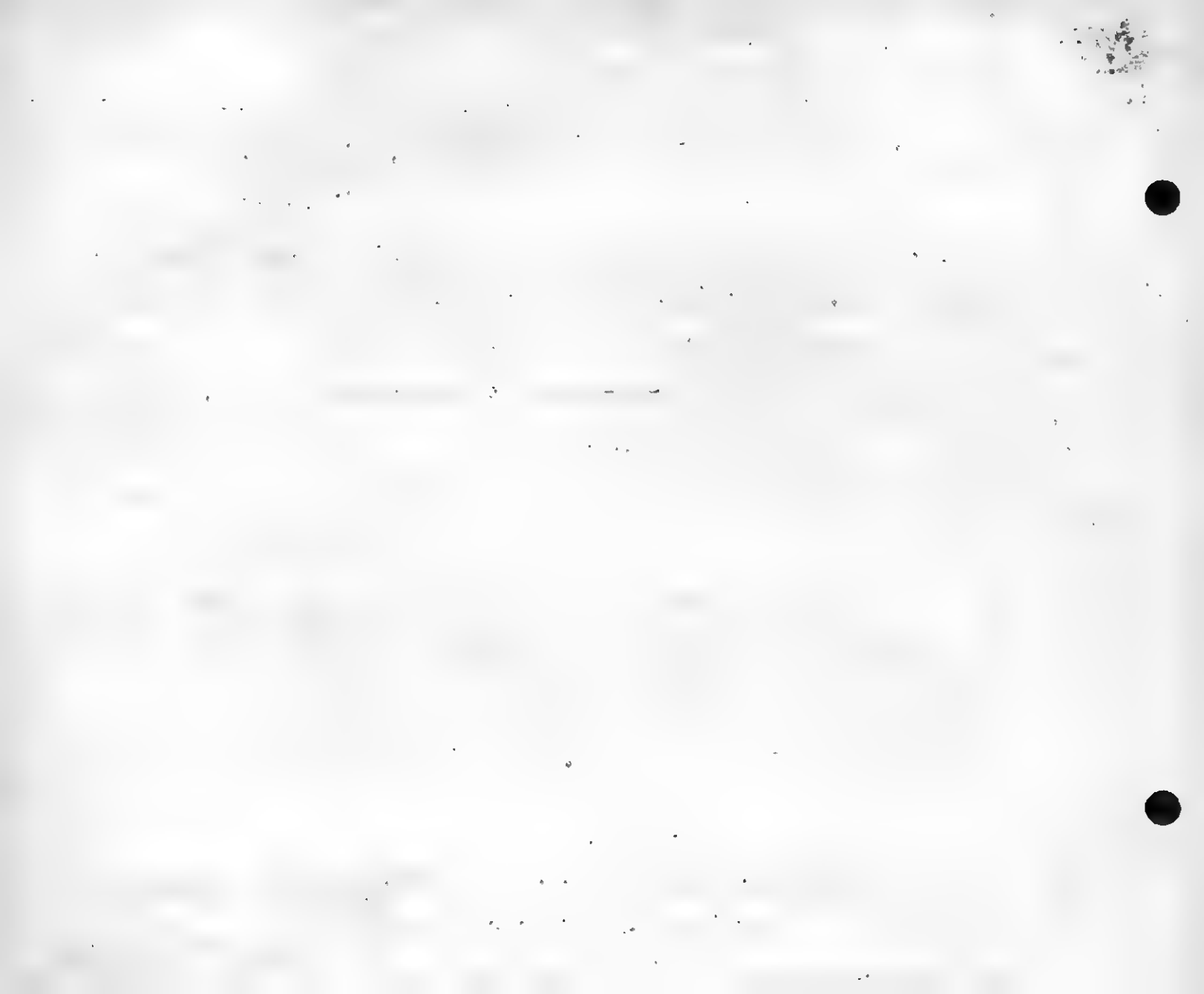


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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

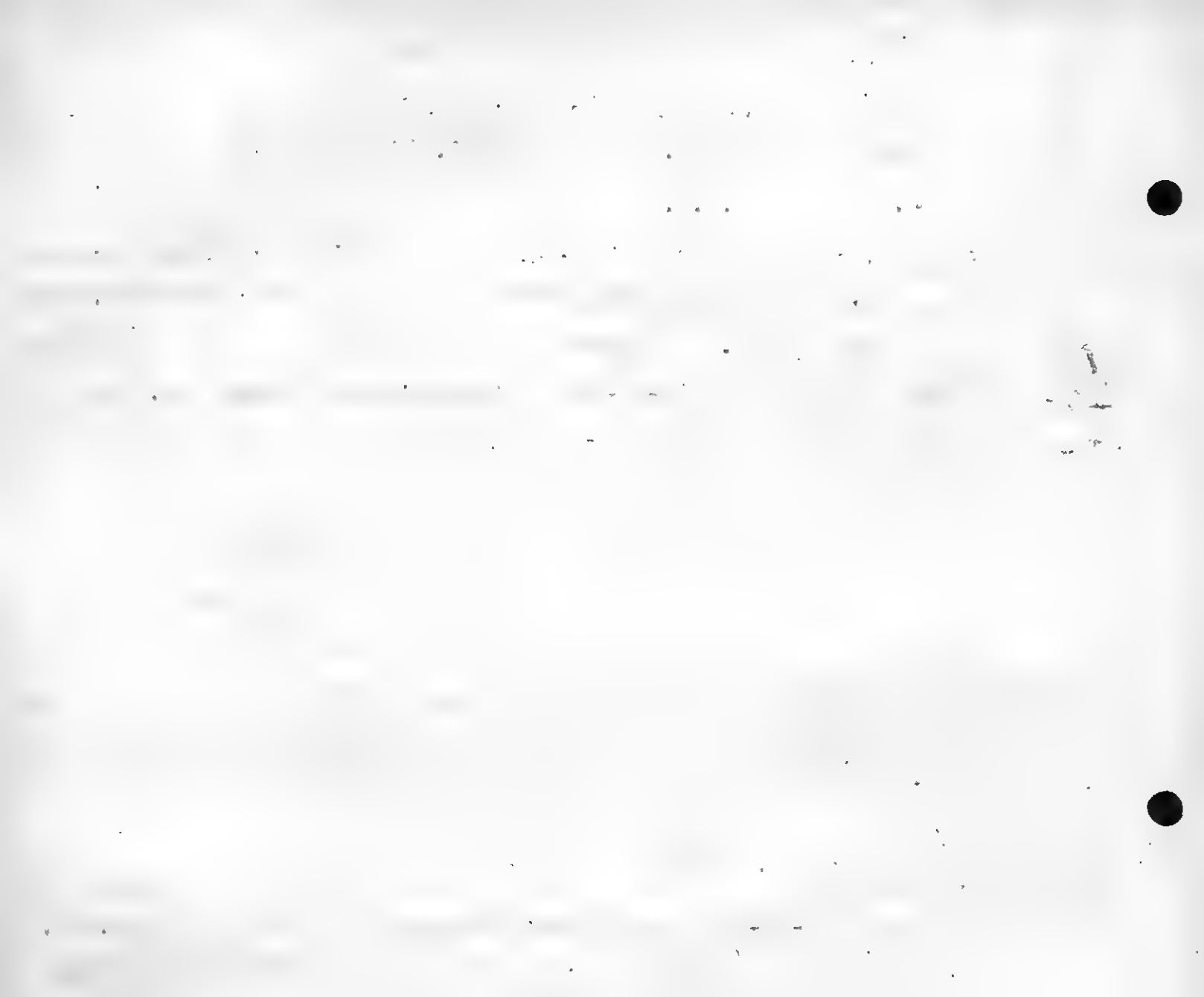
1 DECEASED-NAME (Type or print) <i>Ida M. PAYNE</i>			2a. DATE OF DEATH <i>7-15-68</i>			2b. HOUR <i>5:45</i> M	
3 SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>July 15, 1968</i>		6. AGE (in years lost birthday) <i>79</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i>	
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>button factory</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Federalsburg</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First <i>Joshua F.</i> Middle <i>Covey</i> Last <i>Covey</i>		15. MOTHER'S MAIDEN NAME First <i>Sarah A.</i> Middle <i>Smith</i> Last <i>Smith</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>			
16b. SOCIAL SECURITY NO. <i>218-20-5274</i>		17. INFORMANT <i>John R. Payne</i>				Address <i>Towson, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vermia</i> <i>5700</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic pyelonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i> <i>many yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7-10</i> , 19 <i>68</i> , to <i>7-15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-15-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>		M.D.		22e. ADDRESS <i>Easton, Maryland</i>		<i>7/15/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/17/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Stellensat Cn.</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Harvey W. Williams</i>		ADDRESS <i>Federalsburg, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JUL 17 1968</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Clarice Eleanor Roop</i>						2a DATE OF DEATH 7 Month <i>26</i> Day <i>18</i> Year <i>1968</i>		2b HOUR <i>5:30</i> M			
3 SEX FEMALE		4 RACE CAU.		5 DATE OF BIRTH DEC. 19, 1919		6 AGE (In years lost day) <i>48</i> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Ta Cbot</i>					
10 CITY OR TOWN OF DEATH <i>Easton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINE OPERATOR		12b KIND OF BUSINESS OR INDUSTRY PLASTICS					
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admiss an) STATE MD.		13b COUNTY CAROLINE		13c CITY OR TOWN DENTON		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER LAUREL GROVE RD. RFD			
14. FATHER'S NAME First Middle Last JOHN F. SEWARD				15. MOTHER'S MAIDEN NAME First Middle Last FLORENCE ** CLEVINGER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b SOCIAL SECURITY NO 219-07-0859		17 INFORMANT CLARENCE ROOP, DENTON, MD. RFD		Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> <i>150x</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Yes</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>6</i> —, 19 <i>66</i> , to <i>7-26</i> —, 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-26</i> —, 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Harry M. Walsh</i>						DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 7/30/68	
22d PHYSICIAN'S NAME (Type) Harry M. Walsh		22e ADDRESS Easton, Maryland									
23a BURIAL, CREMATION, REINTERMENT BURIAL		23b DATE 7-29-68		23c NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		23d LOCATION (City or Town) (County) (State) FEDERALSBURG CAR. MD.					
24 FUNERAL DIRECTOR <i>Trampten Lumaad Home Federalsburg Md.</i>		24b ADDRESS		25a REC'D BY REG STRAR AUG 2 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



479-21792

10051

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

751

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) <u>Clinton Satterfield</u>			2a DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>68</u>			2b HOUR <u>9:50</u> AM							
3 SEX <u>M</u>		4 RACE <u>W</u>		5 DATE OF BIRTH <u>NOV 18, 1879</u>		6 AGE (In years last birthday) <u>88</u> YRS		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>			
7a. BIRTHPLACE (State or foreign country) <u>MD</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Talbot</u> Md				
10 CITY OR TOWN OF DEATH <u>Easton</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>ENGINEER</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>RAILWAY</u>				
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital or residence before admission) STATE <u>MA</u>			13b. COUNTY <u>BRIDGEMAN</u>			13c. CITY OR TOWN <u>DENTON</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
14 FATHER'S NAME First <u>THOMAS</u> Middle <u>A.</u> Last <u>SATTERFIELD</u>			15 MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>MURPHY</u> Last <u>MURPHY</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT <u>MISS NETTIE SATTERFIELD, DENTON</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infection</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>arteriosclerosis generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>?</u> <u>10 yrs</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Gangrene left foot amputated above knee.</u>													
19a. DATE OF OPERATION <u>7/10/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gangrene left foot</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> , 19 <u>68</u> , to <u>7/15</u> , 19 <u>68</u> , that (I) was last saw the deceased alive on <u>7/15</u> , 19 <u>68</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.													
22b. SIGNATURE <u>S. T. B. Ambler MD</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/16/68</u>							
22d. PHYSICIAN'S NAME (Type) <u>S. T. B. Ambler</u>		ADDRESS <u>M.D.</u>		22e. ADDRESS <u>Easton, Maryland</u>		22f. DATE SIGNED <u>7/16/68</u>							
23a. BURIAL, CREMATION, OR OTHER DISPOSAL <u>BURIAL</u>		23b. DATE <u>JULY 19, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD MEM.</u>		23d. LOCATION (City or Town) <u>BROOMALL</u> (County) <u>PENNA</u> (State)		24 FUNERAL DIRECTOR <u>CHARLES MOORE DENTON</u> ADDRESS					
25a. REC'D BY REGISTRAR <u>JUL 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH		2b HOUR	
John Alwood Schulz						DATE KNOWN OF DEATH		1968	3:46 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD		2d HOUR
male	white	7-13-18	45 YRS				JULY 27		3:46 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH			
CHESTER		USA				TALBOT			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
EASTON			MEMORIAL			CARPENTER			
13a USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND			QUEEN ANNE			CHESTER		XX	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
OSCAR					SCHULZ	MAUDE			CLOUGH
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
No						MRS. MAUDE SCHULZ - CHESTER, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION									IMMED
4101									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Diabetes mellitus, amp. leg a/c same									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH		P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Louis Welty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		Louis WELTY		Welty		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		7-27-68	
ADDRESS (Street, city, town, or county) EASTON MARYLAND									
23a BURIAL, CREMATION, or other disposition		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
BURIAL		JULY 30		STEVENSVILLE		STEVENSVILLE		MARYLAND	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Edgar L Lane		Church Hill Md		DATE AUG 2 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) John First Segar Middle Segar Last			2a. DATE OF DEATH Month 7 Day 22 Year 68			2b. HOUR 1:27 AM	
3 SEX M		4 RACE W		5 DATE OF BIRTH May 29, 1888		6 AGE (In years last birthday) 80 YRS.	
7a BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md	
1d CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD COUNTY QUEEN ANNE		13c CITY OR TOWN SAME		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME First JOHN Middle SEGAR Last SR			15 MOTHER'S MAIDEN NAME First ELLA Middle DALEY Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT HELEN SEGAR, QUEEN ANNE, MD Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLI CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST (c) CHRONIC OBSTRUCTION EMPHYSEMA 8 YRS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1. 1. 1. STRESS CELLAR							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/18/68 , 19 to 7/22/68 , 19, that (I) (we) last saw the deceased alive on 7/21/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dorsett D. Smith M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/22/68	
22d. PHYSICIAN'S NAME (Type) Dorsett D. Smith M.D.				22e. ADDRESS Easton, Maryland 7/22/68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 26, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City or Town) (County) (State) DENTON CAR, MD.	
24. FUNERAL DIRECTOR CHARLES V. MOORE DENTON ADDRESS				25a. REC'D BY REGISTRAR JUL 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Charles Leslie Shrodes			2a DATE OF DEATH 7 Month 21 Day Year 68			2b HOUR 8 ¹³ A M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH April 15, 1889		6 AGE (In years most birthday) 79 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Talbot	
10 CITY OR TOWN OF DEATH Easton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired- Construction Work		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last Charles W. Shrodes		15 MOTHER'S MAIDEN NAME First Middle Last Margaret Lytle		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			
16b SOC. SEC. NO. 210-03-7023A		17 INFORMANT (Wife) Address Dundalk, Md. Mrs. Kathryn Shrodes, 3707 Old North Pt. Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart block DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours many years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 16 July, 1968 , to 21 July, 1968 , that (I) (we) last saw the deceased alive on 19 July, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b SIGNATURE Stephen P. Canize		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 7-21-68			
22d PHYSICIAN'S NAME (Type) Stephen P. Canize		22e ADDRESS Easton Memorial Hospital, Easton, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 7/24/68		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a REC'D BY REGISTRAR JUL 24 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

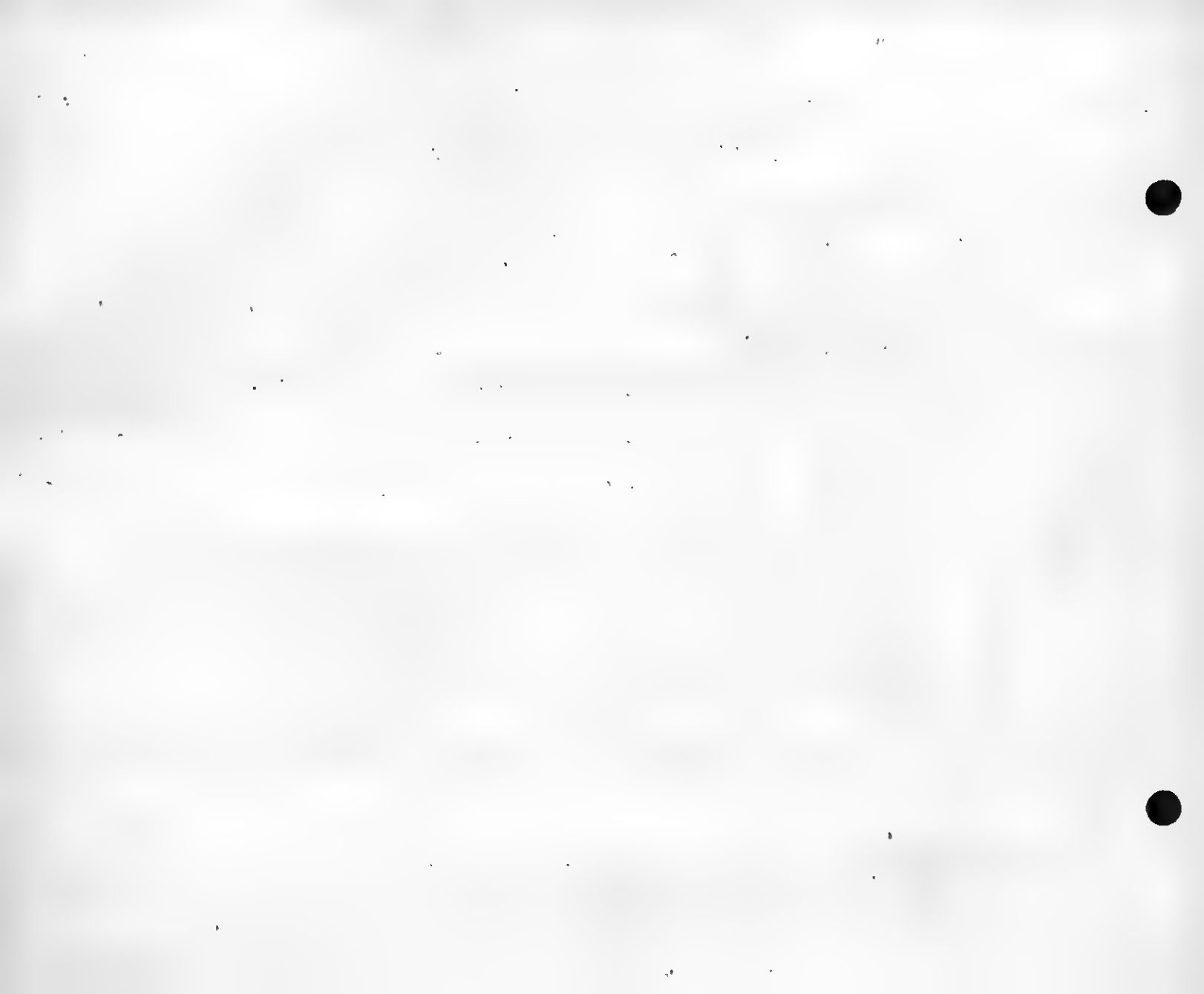
1. DECEASED-NAME (Type or print) First MARY Middle COMFORT Last STANDIFORD			2a. DATE OF DEATH Month July Day 2, Year 1968			2b. HOUR 8:00 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 18, 1879		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Talbot County Md.			
10. CITY OR TOWN OF DEATH Neavitt		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ----		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ----			
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admittance) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Neavitt		3d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER ---	
14. FATHER'S NAME First Middle Last Joseph Keller			15. MOTHER'S MAIDEN NAME First Middle Last Barbara Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Harry G. Standiford, Neavitt, Maryland					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4109 Hypertension DUE TO, OR AS A CONSEQUENCE OF atherosclerotic coronary DUE TO, OR AS A CONSEQUENCE OF artery d. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1953, 19 to 2-2, 1968, that (I) (we) last saw the deceased alive on 2-2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE GUY M. RHESBR, Jr., M.D.		22c. DATE SIGNED 2-3-68		22d. PHYSICIAN'S NAME (Type) GUY M. RHESBR, Jr., M.D.		22e. ADDRESS St. Michaels, Maryland		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		23e. REC'D BY REGISTRAR JUL - 8 1968	
24. FUNERAL DIRECTOR Harrison E. Leonard		24b. ADDRESS St. Michaels, Md.		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last MARY E. Stelle		2a. DATE OF DEATH Month 7- Day 9- Year 68		2b. HOUR 11 05 AM	
3. SEX Female		4 RACE white		5. DATE OF BIRTH 9/11/1891	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years lost birthday) 76 YRS.	
10. CITY OR TOWN OF DEATH EASTON, Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Memorial Hospital		9. COUNTY OF DEATH TALBOT	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b. COUNTY Talbot		13c. STREET AND NUMBER 108 N. Higgins St.	
14. FATHER'S NAME First Middle Last Clifford M. Stelle		15. MOTHER'S MAIDEN NAME First Middle Last Anna Turner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
16b. SOCIAL SECURITY NO. 221-10-0130		17. INFORMANT Clifford M. Stelle, Wilmington, Del.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular fibrillation 4107 DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES NO	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1/Jan, 1954, to 9/July, 1968, that (I) (we) last saw the deceased alive on 15 June 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thornton Harrison		22c. DATE SIGNED 10 July 68		22d. PHYSICIAN'S NAME (Type) THORSTON HARRISON	
22e. ADDRESS Easton, Maryland		22f. ADDRESS		22g. ADDRESS	
23a. B. RIAL CREMATION REMOVAL		23b. DATE 7/12/1968		23c. NAME OF CEMETERY OR CREMATORY Spring Hill	
23d. LOCATION (City or Town) Easton, Md.		23e. LOCATION (County) Talbot		23f. LOCATION (State) Maryland	
24. FUNERAL DIRECTOR Maurice E. Deane, Jr.		24a. DATE JUL 12 1968		24b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		2a DATE KNOWN OF DEATH		2b HOUR	
ELMER CAREY WARNER		7 23 68		8:35 P	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years lost birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS
M	W	Sept 24, 1888	79 YRS	MONTHS DAYS	HOURS MIN.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9 COUNTY OF DEATH Talbot	
10 CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman	
13a. USUAL RESIDENCE (Where deceased lived, if not put on Residence before admission) STATE Maryland		13b COUNTY Talbot		13c STREET AND NUMBER 404 Talbot St.	
14 FATHER'S NAME First Middle Last Samuel Francis Warner			15 MOTHER'S MAIDEN NAME First Middle Last Mary Ellen Lednum		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO 213-05-0314		17 INFORMANT ADDRESS Miss Daisie B. Warner, St. Michaels, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEAD INJURY DUE TO, OR AS A CONSEQUENCE OF (b) AUTO ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-22
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 7-22 1968 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 2 car collision	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rts 301&213		21f LOCATION Street or R.F.D. No City or Town County State nr Centerville QA Md	
22a. I certify that, took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 7-23-68	
EXAMINER'S NAME (Type) Welty		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 26, 1968		23c NAME OF CEMETERY OR CREMATORY Olivet Cemetery	
24 FUNERAL DIRECTOR Harrison E. Leonard		ADDRESS St. Michaels, Md.		23d LOCATION (City or Town) (County) (State) St. Michaels, Talbot, Md.	
		25a REC'D BY REGISTRAR DATE JUL 29 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT 5 (4)
30M REV 1/68

10558
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film 6402 2000 11
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) WILLIAM SETH WILLIS			2a DATE OF DEATH Month 7 Day 11 Year 1968			2b HOUR M			
3 SEX M.		4 RACE W.		5 DATE OF BIRTH 8/29/1905		6 AGE (in years last birthday) 62 YRS.		7 IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT			
10 CITY OR TOWN OF DEATH RURAL EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H. M. NEEDWOOD FARM		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMY SALES		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND COUNTY TALBOT		13b CITY OR TOWN R. EASTON		13c INSIDE CITY, J.M.T? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
14. FATHER'S NAME First Middle Last J. McKENNA WILLIS			15 MOTHER'S MAIDEN NAME First Middle Last WILLEMINT SETH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 412-10-5556		17 INFORMANT Address MRS WM S. WILLIS RURAL EASTON					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of Pancreas DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 10/11 New									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the undersigned) attended the deceased from Sept. , 19 66 , to 7/11 , 19 68 , that (I) (we) lost saw the deceased alive on 7/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert M. McDonald				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 7/11/68			
22d. PHYSICIAN'S NAME (Type) Robert M. McDonald, M.D.				22e. ADDRESS S. Hanson St., Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 7/13/68		23c NAME OF CEMETERY OR CREMATORY WINDLAWN MEMORIAL		23d LOCATION (City or Town) (County) (State) R. EASTON TA. MD			
24. FUNERAL DIRECTOR Robert East				25a REC'D BY REGISTRAR JUL 15 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10653 Item #1, 13b, 16b, Film G MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10667											
1. DECEASED-NAME (Type or Print) <i>ALLAN S. Willson</i>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <i>1968</i>			2b. HOUR <i>10A M</i>		
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>12/8/1915</i>		6. AGE (In years last birthday) <i>52</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Talbot</i>		
10. CITY OR TOWN OF DEATH <i>Easton</i>				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Route 50</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Security officer General Motors</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Talbot</i>				13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Allan H. Willson</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Mignonette Townsend</i>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give year and dates of service) <i>1941-1945</i>			
17. INFORMANT ADDRESS <i>Mrs. Mildred Willson, Baltimore, Md.</i>								18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF <i>4109</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Lewis D. Nulty</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>7-4-68</i>			
EXAMINER'S NAME (Type) <i>W-LTS</i>				ADDRESS (Street, city, town, or county) <i>Easton Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>July 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WOODLAWN MEMORIAL PR.</i>				23d. LOCATION (City or Town) (County) (State) <i>EASTON TALBOT MD.</i>	
24. FUNERAL DIRECTOR <i>Maurice E. Newman & Son</i>				ADDRESS <i>Easton Md.</i>				25a. REC'D BY REGISTRAR <i>WUL - 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

Volume 11

Number 11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) FRANCIS MOORE WOOD						2a. DATE OF DEATH Month July Day 10 Year 1968			2b. HOUR 3:50 M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 29, 1912			6. AGE (In years / last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 704 WYE AVE			
14. FATHER'S NAME First OSCAR Middle MOORE Last ETTA SMITH				15. MOTHER'S MAIDEN NAME First ETTA Middle SMITH Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) X (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. XX		17. INFORMANT EARLE B. WOOD			Address EASTON, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (his/her) attended the deceased from 4-16 , 19 68 , to 1-10 , 19 68 , that (I) (we) last saw the deceased alive on 1-10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Stephen P. Carney DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-10-68				
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.						22e. ADDRESS Easton, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 12, '68		23c. NAME OF CEMETERY OR CREMATORY SPRING HILL		23d. LOCATION (City or Town) EASTON (County) TAL. (State) MD						
24. FUNERAL DIRECTOR Charles Judge		ADDRESS Easton, Md		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

